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Analyzing the Process of Health Financing Reform in South Africa and Zambia: Zambia Country Report

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Abstract

This report presents the findings of the Zambian country study undertaken as part of a two-country project called *Analyzing the process of health sector reform in South Africa and Zambia* (also known as 'the SAZA project').

The report presents an analysis of the experience of health care finance reform in Zambia from 1990-1999, beginning with the period immediately preceding the multiparty elections in 1991.

Why was the study undertaken?

Health financing reforms that aim to improve resource availability and use are a central component of the current wave of health sector reforms both in sub-Saharan Africa and in other parts of the world. However, there has been little systematic evaluation of reform experience. This study was, therefore, initiated to better understand the process of developing and implementing such reforms and to generate information that may support policy makers and planners in the countries of focus and around the world.

Where was the study undertaken?

The study was undertaken in South Africa and Zambia, two sub-Saharan countries that have introduced wide-ranging health financing changes in recent years. The experience of these countries is expected to be of relevance to other countries within the region and around the world.

What makes this study different?

The study has three important features that distinguish it from other research on health reforms in middle and low-income countries:

> While the study looked at the impact of reforms on all of their stated policy objectives, it focused on the issues of equity and health system sustainability, which have been subjected to less scrutiny internationally than, for example, efficiency.

> The major contribution of the study is its emphasis on the process by which policies are developed and implemented, and the factors facilitating or constraining their effectiveness.

> The study also considered the linkages between different financing reforms and between financing reforms and other health sector reforms (in particular, decentralization), to ensure a comprehensive understanding of reforms.

What are the reforms of interest?

The range of reforms that have been considered are as follows:

> geographic resource allocation formulae;

> user fees (in South Africa, the removal of primary care fees and in Zambia, the implementation of a full-fee schedule); and

- health insurance options (in South Africa, formal social health insurance and in Zambia, less formal, prepayment schemes).

Who has conducted the study?

A multidisciplinary research team of health economists and health policy analysts has been assembled, linking research institutions in two African and two European countries. The following research institutions are involved:

- Centre for Health Policy, University of the Witwatersrand (South Africa)
- Department of Economics, University of Zambia (Zambia)
- Health Economics Unit, University of Cape Town (South Africa)
- Health Policy Unit, London School of Hygiene and Tropical Medicine (UK)
- Institute of Health Economics (Sweden).

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Acronyms

BOP	Balance of payments
CBOH	Central Board of Health
CHESSORE	Center for Health Science and Social Research
CMAZ	Churches Medical Association of Zambia
CSO	Central Statistics Office
DANIDA	Danish International Development Agency
DCB	District Capacity Building
DFID	Department for International Development, UK (formerly ODA)
DGIS	Netherlands Government Directorate General for International Cooperation
DHB	District Health Board
DHMT	District Health Management Team
DSW	Department of Social Welfare
DWAC	District Welfare Assistance Committee
FAMS	Financial and Administrative Management System
FEMAC	Foreign Exchange Management Committee
FHANIS	Food Security, Health and Nutrition Information System
GDP	Gross domestic product
GNP	Gross national product
GRZ	Government of the Republic of Zambia
HCCS	Health Care Costs Scheme
HCFWG	Health Care Financing Working Group
HEFP	Health Economics and Financing Program
HMIS	Health Management Information Systems
HRIT	Health Reform Implementation Team
IFIs	International Financial Institutions
IMF	International Monetary Fund
LAP	Leadership, accountability, and partnership
LCMS	Living Conditions Monitoring Survey
LR	Level Referral
MCDSS	Ministry of Community Development and Social Services
MMD	Movement for Multiparty Democracy

MMI	Mwase Mphangwe Initiative
MOF	Ministry of Finance (to 1996)
MOFED	Ministry of Finance and Economic Development (from 1996)
MOH	Ministry of Health
MOU	Memo of Understanding
NCDP	National Commission for Development Planning (to1996)
NDP	National Development Plans
NERP	New Economic Recovery Program
NGO	Nongovernmental organization
NHC	Neighborhood Health Committee
NHI	National Health Insurance
NHPS	National Health Policies and Strategies (MOH policy document)
OPD	Outpatient Department
PAG	Participatory Assessment Group
PACU	Provincial Accounting and Control Unit
PFP	Policy Framework Paper
PHC	Primary health care
PHR	Partnerships for Health Reform
PMO	Provincial Medical Officer
PSMAS	Public Servants Medical Aid Scheme
PSRP	Public Sector Reform Program
PWAS	Public Welfare Assistance Scheme
RAWP	Resource Allocation Working Party
RDCs	Recurrent departmental charges
RDSB	Rural Development Studies Bureau
RHA	Regional Health Advisors' offices (formerly PMO's offices)
SA	South Africa
SAP	Structural Adjustment Program
SIDA	Swedish International Development Agency
TA	Technical advisor
U5MR	Under Five Mortality Rate
UK	United Kingdom
UNICEF	United Nations Children's Fund
UNIP	United National Independence Party
UNZA	University of Zambia

USAID	United States Agency for International Development
UTH	University Teaching Hospital
WB	World Bank
WHO	World Health Organization
ZADECO	Zambia Democratic Congress
ZANECO	Zambia National Commercial Bank
ZCCM	Zambia Consolidated Copper Mines

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Many people have given us their time and support during the course of the Zambia country study of this project, in agreeing to be interviewed, lending us documentation, and providing us with feedback on our analyses. Although too numerous to mention individually, we could not have produced this report without their views, comments, and input, and we are sincerely grateful to all of them.

We would like to thank the Ministry of Health and Central Board of Health for approving the study way back in 1996, and also participants of the Ministry of Health/Central Board of Health/Department of Economics "Health Policy and Economics workshop" held in November 1999 at Kafue Gorge, Zambia, for giving us the opportunity to present initial findings and obtain comments. We would also like to thank the external reviewers of the draft report, Dr. J. J. Banda, formerly of the Central Board of Health, and Professor Anne Mills at the London School of Hygiene and Tropical Medicine.

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We take full responsibility for our final conclusions.

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Executive Summary

Background

Many countries of sub-Saharan Africa have substantially reformed the mechanisms used for health care financing during the past two decades; however, the evaluations available suggest that policy reform has frequently not achieved its identified goals. Furthermore analysis from other sectors suggests that the process of policy formulation and implementation is likely to be a key factor affecting impact.

Since the change of government in Zambia in 1991, the Ministry of Health (MOH) has developed and implemented a number of new mechanisms to both mobilize and allocate resources within the sector. These financing reforms have been subordinate to the primary reform strategy of the creation and strengthening of decentralized structures for health service organization and management level. This study reviews experience with selected financing mechanisms to highlight areas where change in design or process may be beneficial in terms of both the stated objectives of the reforms and their overall impact on equity and sustainability within the health care system. A similar study, using the same methods and approaches, was undertaken in South Africa.

Aims and Objectives

The overall aims of the project were the following:

- Strengthen the implementation of critical financing reforms in South Africa and Zambia
- Deepen international understanding of the factors facilitating and constraining the selected reforms' contribution to the broad performance goals of equity and health system sustainability.

Within the Zambian country study the specific objectives were the following:

- Document the evolution of specific health care financing reforms in relation to design, steps in policy formulation, and initial implementation, as well as to understand the linkages between these reforms and between these reforms and parallel institutional change
- Analyze retrospectively the critical factors facilitating and constraining the development and initial implementation of selected reforms
- Critically appraise the selected reforms' potential, or, where possible, actual contribution to the broad performance goals of equity and health system sustainability.

Methods

The main period of focus for this study was 1990-1999, i.e., beginning with the period immediately preceding the multiparty elections in late 1991 in Zambia. Table ES.1 lists the reforms studied.

Table ES.1. Reforms Covered in the Study

Type of Rreform	Specific Reform
Resource mobilization	Formal introduction/expansion of user fees throughout the public health system
	Introduction of prepayment
	Development of exemption policy
Resource allocation	Development of interdistrict resource allocation formulae
	Budgetary reform to reallocate resources between levels of care
Parallel, institutional reforms	Strengthening of the district health system with formal autonomous boards Increased autonomy to referral hospitals

Drawing on the policy analysis approach of Walt and Gilson (1994), the study examines four sets of factors influencing various steps in the process of policy formulation and implementation: policy context, actors, policy content, and policy processes. With respect to the reforms of focus (identified in Table 1), the study sought to answer the following:

> What are the consequences of the reform; in particular, did it achieve intended impacts?

> How did the policy process, in particular the four factors identified above, influence the impact?

The study was pursued in three phases:

> Phase 1 - Identification of reform chronology, key aspects of context, and key actors

> Phase 2 - Detailed analysis of factors affecting policy process and reform impacts

> Phase 3 - Report writing and further analysis as needed.

A variety of research methods were used, including the following:

> Capture of researchers' own knowledge

> Review of key policy documents and evaluation reports

> Interviews of key informants, including informed and accessible policy makers, managers, donors, analysts, and technical advisors central to reforms in general or to specific reforms

> Analysis of limited media

> Collection of secondary data for impact analysis.

The study combined use of qualitative and quantitative methods of evaluation. Qualitative approaches were largely used in assessing the factors facilitating and constraining the reforms of focus, and quantitative and qualitative methods were combined in analyzing the actual and potential impact of these reforms. In terms of impact, the study focused on analyzing the impact on the goals of equity and sustainability, both of which are central to the Zambian government.

The Context of Health Financing Policy Development

The reforms of focus were developed in a very particular context. First they were developed under a new political regime, that of the Movement for Multiparty Democracy (MMD), which came to power in 1991 in the first multiparty democratic elections held in Zambia since independence. The Zambian economy, during the previous United National Independence Party (UNIP) regime, had faced long-term decline. MMD on coming to power implemented a package of donor-supported austerity measures, which have not yet borne fruit. Poverty during the UNIP regime (1964-1991) had become entrenched and continues to increase. In terms of health, poverty-related illnesses are widespread and compounded by the heavy burden of HIV/AIDS. Although there had been a large increase in health infrastructure during the UNIP regime, this had not been matched by a corresponding increase in social sector funding such that by 1990 the health care system was near collapse.

In this broad context, health sector reform was seen to be critical to provide lasting solutions to the health sector's problems. The principles and key ideas of the reform program were set out in the National Health Policies and Strategies (NHPS) document, which has provided the primary framework for reform. The MOH then embarked upon a radical program of health reforms, which involved a wide array of strategies, including decentralization, management systems development, infrastructure rehabilitation, human resource development, essential drugs, the essential package, and resource allocation, among others. Within this package of reforms, decentralization was seen as the key strategy for restructuring the health sector, with the creation of district health boards and hospital boards as well as the separation of the political and executive functions of the MOH.

The Development of Health Financing Policies

In 1991 when the MMD came to power there was a relatively clear, albeit broad, policy position on health financing. Surprisingly little progress has been made to finalize a more comprehensive and operational policy spelling out the relationship between the organizational and financing reforms and between different financing mechanisms. By the end of 1999 the official MOH health financing policy had still not received cabinet approval, despite a five-year on/off process of consultation and drafting.

The primary objective of cost sharing (revenue raising versus partnership with users) and the preferred modality (user fees versus prepayment in cash and/or in-kind) have both changed within the study period. A succession of ministers has made pronouncements on a seemingly ad hoc basis, and official guidelines for providers and users have only recently been issued. Resource allocation reform has followed a more linear development. Initially reforms took place within the context of sectoral decentralization; however, there has not been much further refinement of the initial resource allocation mechanisms despite an acknowledged need to do so.

The Impact of Financing Policies

Understandably, the impact of a package of reforms that differ substantially (e.g., between rural and urban areas), and have been implemented over nearly a decade, is complex. The analysis of the impact is based largely on a synthesis of existing studies with only a limited degree of primary data collection.

Many studies have been conducted on the impact cost sharing has had on utilization, and they have shown that the introduction of user fees around the country has tended to reduce health service

utilization, although more recently, in some areas, utilization may have stabilized or even risen. An exemption policy appeared to work relatively well in protecting patients categorized by demographic features, particularly age, from payment, but it does not seem to have worked well in terms of promoting access for those unable to pay fees. Revenue generation from user fees and prepayment schemes has been relatively low in relation to the cost of providing services. In general the evidence concerning the impact of fee revenue on perceived quality is contradictory and limited. There is however some limited evidence that cost sharing has contributed to a greater sense of accountability to patients among providers.

In terms of the impact of resource allocation reform, the introduction of the formula has had a clear positive impact on geographical equity. However the effect is more marked in government budgets than in actual expenditures. To the extent that a reduction in the share of government funding going to hospitals and administration can be viewed as an increase in efficiency, the Zambia experience has been quite remarkable in international terms, with an average annual decline of 1.9 percent per annum in hospital funding during 1990-1998. The extent to which this budget commitment has been borne out in terms of actual expenditure is again less drastic, but still quite impressive. Between 1995 and 1999 the share of district spending in total spending increased from 40 to 52 percent, which translated into an absolute increase in funding of around 15 percent. Resource allocation reform (specifically the devolved budgetary control) has had a further positive but indirect impact on efficiency and thus sustainability. Financial management capacity at district and facility level was strengthened in response to new budgetary responsibilities and has contributed to the development of organizational capacity in a decentralized context.

The Effects of Reform Design upon Impact

While the government has successfully implemented exemption schemes to cover certain categories of the population (notably children), schemes to protect those unable to pay are poorly developed. Moreover the fact that health staff may use a part of revenues from cost sharing to pay staff bonuses creates disincentives to exempt patients. One positive design aspect is that with the inception of cost sharing, revenue was to be retained at the local level. In actual implementation, however, this has not worked well as the policy guidance was that health centers and district hospitals should remit revenues to the district and then apply to get them back. For hospitals, particularly referral hospitals, retaining user fee revenues has become an important source of income. At the primary care level the fact that revenues provide a source of discretionary income is important, but there is also evidence that health centers have administrative difficulties in accessing revenues they have submitted to districts. Aspects of poor design in prepayment schemes (such as rules that encourage adverse selection and abuse of the prepayment card) also cause problems for sustainability.

Resource allocation reforms have successfully moved Zambia away from funding patterns primarily reflecting existing infrastructure to a system of population-based funding. There have been problems, however, mainly because of a lack of reliability in population data and an initial allowance that was made to the infrastructure. Resource allocation formulae still cover a relatively small part of the total government budget (as drugs and salaries are excluded).

The impact of financing policies also appears to have been affected by failure to coordinate different types of financing policies and to coordinate financing policies with organizational reforms. For example, the lack of coordination between the design of user fee schemes and prepayment schemes contributed to hospital overcrowding during the mid-1990s. The issue of drug availability has been a constant problem with regard to the design of cost-sharing schemes. Despite the recent development of a drug policy, at the end of the study period the nonavailability of drugs was still an impediment to effective cost sharing.

The Effects of Policy Processes upon Impacts

Reforms took place in a window of political opportunity after the elections. Although both the political and administrative environment was highly supportive of the reform process, the economic context was, and continues to be, very poor—a factor that has inhibited the success of the financing reforms of focus.

The importance of the political dimension of health reforms contributed to the key role ministers of health played in shaping both the content and process of financing reforms. Each individual minister placed his or her own personal stamp on the reforms; consequently, ministerial changes led to apparent inconsistencies or reversals of policy. The relative power of ministers in the financing reform process was also enhanced by the limited capacity within the MOH to undertake analysis of financing options and champion particular health financing policies.

The politicization of the reform process also contributed to the problems the Health Care Financing Working Group (HCFWG) faced in attempting to take an effective role in shaping policy. However, the fact that the HCFWG did not always have a clear remit or place in the organizational structure made it easier to ignore the advice of this technical body. Donors and technical advisors appear to have played a largely supportive role in the reform process; however, their role was also influenced by the limited capacity within the MOH, and as a consequence, there was sometimes limited local ownership of financing reform implementation strategies (in contrast to the strong local ownership of the overall policy direction).

Reforms in Zambia are unusual in that they have a clear guiding vision to direct them; however, for cost-sharing reforms this vision was neither specific nor consistent. Resource allocation reforms were much more clearly rooted in the guiding vision (as articulated in the NHPS) and were better integrated into organizational reforms. Resource allocation reforms also appeared to benefit from the fact that they were never as politicized as cost sharing and hence technocratic advice probably played a stronger role.

While the government made considerable effort to consult with different groups during the process of developing financing policies, it was extremely weak in terms of communicating policies to two key sets of stakeholders: health staff and the general population. In addition proper monitoring and evaluation plans were never integrated into implementation plans. Where evaluations of financing reforms were conducted, their impact appears to have been mixed, depending largely upon the political environment at the time they were conducted.

A core thrust of the reforms was to shift resources away from hospitals towards primary care. As such, it is not surprising that hospital staff emerge as key opponents to specific aspects of cost-sharing policy as well to the overall financing policy. Ministers who were not entirely in agreement with the overall reform vision as set out in the NHPS often sought, and found, their power base within the hospital sector.

Lessons for the Process of Policy Formulation

Change in Zambia was politically driven. Radical reforms commonly have a political dimension. Under circumstances such as those in Zambia, it is critical that there are strong institutions to prevent politically driven change from becoming overwhelming. Suggestions to strengthen institutions for health financing reform in Zambia include the following:

> Develop more technical health economics capacity, especially within government, but also

in local institutions outside government, such as the university

- Reestablish a HCFWG to coordinate activities in this area
- Finalize the health financing policy framework so that a clear set of overarching goals and structures are in place
- Prioritize reforms and sequence reforms with care so that scarce capacity is not overstretched
- Increase the level of consultation and communication with health staff at the periphery and with the general population
- Maintain dialogue with other branches of government so that reforms within the health sector are in harmony with reforms planned in other sectors.

Lessons for Strengthening Technical Design

- Ensure clarity of objectives for health financing reform as this is required to ensure rational technical design of reforms
- Strengthen the exemptions system, particularly for those unable to pay user fees
- Recognize and build upon the links between health financing reform and broader organizational reforms.

Lessons for Strengthening Financing Policy Implementation

- Involve implementors more during the policy process so that policy design corresponds to the situation on the ground and is feasible to implement
- Build capacity (both skills and financial systems) to monitor better cost sharing and resource allocation reforms.

Report Structure

This report presents the analysis of experience around financing reform in Zambia through eight inter-linked sections.

- Section 1: Presents the objectives of this study, with reference to international experience in evaluating health financing reform.
- Section 2: Identifies the period and reforms of focus for this Zambian country study and gives details of the data collection and analysis methods.
- Section 3: Describes the context in which health care financing reform was undertaken in Zambia, identifying the key contextual factors that have influenced the pattern and pace of reform development and implementation.
- Section 4: Identifies the roots of, and key steps in, the evolution of financing changes in the

1990-99 period, including the policy community involved in these developments and details of the policy design for the reforms of focus. This outline provides the background for the more detailed analysis of these experiences presented in the remaining sections.

- Section 5: Presents analyses of the impact of those reforms that have already been implemented, i.e., the introduction or expansion of user fees and prepayment, and resource reallocation, on equity and sustainability.

- Section 6: Identifies some of the key factors relating to the design of health financing reforms in terms of their influence on equity and sustainability impacts described in Section 5.

- Section 7: Analyzes the range of factors that have influenced the development and implementation of the reforms of focus and therefore shaped their impact.

- Section 8: Presents conclusions derived from the analysis of Sections 5 to 7 for both national and international policy makers, managers, and health policy analysts.

1. Background

1.1 Justification

1.1.1 The Need to Evaluate Health Care Financing Reforms in Sub-Saharan Africa

Facing a scarcity of resources and inefficiency in resource use, changes in health care financing mechanisms have been a central element of the reforms introduced within public health systems across sub-Saharan Africa over the last 15 to 20 years. These reforms have included both resource mobilization measures (such as the introduction or increase of user fees) and resource allocation mechanisms.

Both represent and require major changes within public health systems, yet despite their importance, few evaluations of experience with these reforms were available in the mid-1990s. Most reported experience concerned cost recovery mechanisms, and that experience had largely been disappointing (Gilson 1997a). Policies were often found to contribute little to their commonly stated goals of resource mobilization and improved efficiency of resource use. At the same time, they clearly had the potential to adversely impact other policy objectives, such as equity and health system sustainability. In some cases, the experience of implementing cost recovery mechanisms had led to policy reversal (Collins et al., 1996).

Even less was known about the factors that determined whether policies achieved their goals or those factors that acted as barriers to goal achievement. Broader public sector reform experience (e.g., Grindle and Thomas 1991; Haggard and Webb 1993; Nelson 1990; Toye 1992) suggested that the processes of policy formulation and implementation were likely to be important influences. Delays and reverses in reform implementation had, for example, been shown to result from obstacles such as conflict over policy goals between different interest groups, a lack of relevant information, and limits on the institutional capacity available to design and implement reforms. The key implication of these analyses is that understanding how such factors influence the pattern, pace, and impact of reforms is important in strengthening reform efforts. Such understanding can, in particular, support early action to tackle potential obstacles, which is in itself a critical element both in turning reform ideas into changes on the ground and in bringing about positive impacts through these changes. As Brinkerhoff (1996: 1395) has said:

> *Successfully pursuing long-term reforms in democratising environments involves not just knowing in which direction to move, but paying attention to how to get there.*

Yet in the health sector most evaluation of reforms was based on the simple assumption that the design or content of the reform was the critical explanation of success or failure. "As a result, policy changes have often been implemented ineffectively and expected policy outcomes have not been achieved." (Walt and Gilson 1994: 366)

The study, therefore, seeks to respond to the concern that "Policy analysts cannot continue to ignore the how of policy reform." (Walt and Gilson 1994: 366)

1.2 Purpose, Aims, and Objectives

This Zambian country study sought to undertake in-depth analysis of the factors facilitating or constraining the potential of key reforms to achieve change in order to contribute to national and international policy debates concerning health care financing reforms. A second country study in South Africa (SA) was undertaken in parallel (Gilson et al., 1999).

The following were the overall objectives of the study as a whole:

- Strengthen the implementation of critical financing reforms in South Africa and Zambia
- Deepen international understanding of the factors facilitating and constraining the selected reforms' contribution to the broad performance goals of equity and health system sustainability.

Within the Zambian country study, the specific objectives were the following:

- Document the evolution of specific health care financing reforms in relation to design, steps in policy formulation, and initial implementation, as well as the linkages between these reforms and between these reforms and parallel institutional change
- Analyze retrospectively the critical factors facilitating and constraining the development and initial implementation of selected reforms
- Critically appraise the selected reforms' potential, or, where possible, actual contribution to the broad performance goals of equity and health system sustainability.

1.3 Areas of Focus

1.3.1 Factors Facilitating or Constraining the Development and Implementation of Health Care Financing Reforms

A first step in this project was to review existing analyses of health reform experience (Gilson 1997b). This review confirmed that the way in which health care financing reforms have evolved is as likely to have had a critical influence over the changes they generate as would their specific design.

Specific factors that were found to influence the pattern, pace, and impact of reform include the following:

- Importance of actors or stakeholders and their potential to block reforms; this is tied to the balance of power between different actors, often rooted in and shaped by conflict over the values and goals underlying reforms
- Potential of reforms to alter the balance of power between actors as a result of the introduction of new or changed incentive structures
- Strategies of policy development and implementation, including the differing contributions of incremental and radical implementation strategies in relation to different contexts, such as the potential of speedy implementation during a "window of opportunity" to deliver

change, but also the importance of building consensus and support for change through an incremental process

- Mechanisms used in policy development as strategies for building consensus, legitimizing reforms, or even for deliberately delaying change (such as formal committees of inquiry)

- Importance of organizational capacity to successful reform, including both the formal skills and procedures within and between organizations, information and other resource availability, and the informal social networks that promote common working practices and support achievement of organizational goals

- Underlying contextual factors that shape the values underlying reforms and actors' behavior, as well as determining the nature of selected reform proposals.

In general, Walt and Gilson (1994) suggest that these different factors can be categorized into four groups: context, the processes of policy formulation and implementation, actors, and policy content or design. The term "process" in this instance encompasses the steps in any process of policy change (i.e., agenda setting, design development, implementation and evaluation) and their timing; the strategies used within these steps to, for example, build legitimacy, consensus, or capacity; and the specific mechanisms or bodies established to move forward.

1.3.2 Design Features That Influence Reform Impact

There are two ways in which the specific design of any reform can influence the degree of change and its impact. First, design details shape actors' responses—whether in support of or against the reform. Second, through their influence over provider and user behavior, these design details directly determine how the reform will impact equity and efficiency, as well as its sustainability. The design features of importance, by reform type, include the following:

a) For resource mobilization reforms, e.g., user fees, prepayment, or social health insurance (Doherty 1997a; Gilson 1997a; Lake 1997) –

- Fee or premium levels

- Services for which fees are introduced or that are covered through prepayment or social health insurance

- Degree and range of exemption mechanisms within user fee systems, or the extent of risk sharing achieved through prepayment and social health insurance

- Mechanisms for using revenue.

b) For resource allocation mechanisms (Doherty 1997b) –

- Criteria used to weight populations for need

- Inclusion of "special allocations" within formulae

- The link between formulae components and the budget structure.

Past experience also suggests that introducing financing changes, singly or in combination, can have an impact. For example, cost recovery mechanisms are commonly introduced without consideration of the complementary resource reallocation mechanisms that are important in preventing the geographical inequities that could otherwise result from revenue retention at local levels. At the same time, the resource mobilization potential of such mechanisms is likely to be enhanced by their linkage to prepayment and other insurance mechanisms (Gilson 1997a).

In addition, the success of financing reforms seems to require implementation of a complementary package of institutional changes. Such changes include the following:

- Development of accounting and management capacities
- Decentralization of revenue use control
- Quality of care improvements
- Redesigned information systems
- Effective community involvement in the design and management of financing schemes
- Design of exemption mechanisms that target those unable to pay
- Stronger personnel recruitment and promotion practices.

Many analysts suggest that there is an important synergy between financing reforms and decentralization of decision-making authority. This is tied to the understanding that decentralization can develop the managerial capacity required to allow effective implementation of new reforms. Bringing management closer to the population will allow the appropriate and efficient use of revenues raised through new resource mobilization initiatives. However, real decentralization of authority may itself require financing reforms to mobilize or allocate resources to newly established decision-making bodies (Gilson et al., 1994). Effective implementation of financing reforms is likely, therefore, to require consideration of what responsibilities to decentralize, to whom and when. This "sequencing" of reform implementation—the phased introduction of different changes over time and in recognition of their relevance to each other—is increasingly seen as an important element of successful reform (Leighton 1996). Although there are concerns about the dangers of initiating too much change at one time, some suggest that a comprehensive approach to reform will be more effective than piecemeal change (Gilson and Mills, 1996; Møgedal et al., 1995).

1.3.3 Key Implications for the Project

Experience with health financing reform emphasizes the importance of initiating an evaluation early in the process. This will help guide and fine tune the further development and implementation of the reform. Such evaluations should not only seek to measure the impact achieved through reform, but also explore the factors that influence the nature and extent of change achieved. In other words, it is important to consider how the actors involved in the process, as well as the design and institutional context of the reform, shape its impact. Such an analysis can inform national and international policy makers about how to manage processes of change more effectively and thereby enhance the extent of change achieved.

Given the difficulty of disentangling the various factors influencing reforms, there is also growing recognition of the need for new evaluation approaches to assess these diverse issues (Janovsky and Cassels, 1996). Conducting a comprehensive assessment of financing reform can, thus, contribute to the development of methods to explore the processes and context of policy making and implementation, and help better define the less readily quantifiable impacts of reform.

1.4 Relevance of Study to Zambia

As part of a broad package of reforms introduced in the Zambian health sector since the change of government in 1991, the Ministry of Health (MOH) has developed and implemented a number of new mechanisms for mobilizing and allocating resources within the sector. However, these have been subordinate to the primary reform strategy of the creation and strengthening of decentralized structures for health service organization and management at the district and hospital level.

Resource mobilization reform in particular has been regarded as one of the less successful areas within the reform package, yet it is highly visible to the Zambian public. For example, the reintroduction of official user fees at hospitals in 1992 and elsewhere in the system in 1993 was not accompanied by the sensitization of health workers or the public. As a result, the change has led to constant complaints that people are paying without seeing any benefits. The introduction of a succession of different mechanisms has led to confusion and inconsistency in cost-sharing implementation, yet there has been relatively little research on this subject.

Both decentralization and financing reforms appear in official ministry policy documents. However, both Zambian policy makers and donor partners focused their initial attention on organizational reform. To clarify the position regarding sectoral financing, and in belated recognition of the need for a clear policy consistent with and complementary to the decentralization strategy, there has been an effort for more than five years to develop and finalize a comprehensive health financing policy. This is required in order to provide the overall framework for more detailed guidelines to implementors and to the public regarding their respective rights and responsibilities in sharing costs. The need to further refine resource allocation mechanisms to better incorporate concepts of need has also risen higher on the policy agenda.

This study aims to review the progress of some of the various mechanisms that have been implemented to date in order to highlight areas where change in design or process may be beneficial in terms of stated objectives of the reforms and their overall impact on equity and sustainability within the health system. Few studies of resource mobilization reforms in Zambia have looked at factors other than impact, and no studies have been undertaken to date on resource allocation. This research is therefore both timely and directly relevant in terms of ongoing policy debates within the Ministry of Health and its partner agencies.

2. Study Focus and Approach

2.1 Period of Focus

The main period of focus for this study was 1990-99, i.e., beginning with the period immediately preceding Zambia's multiparty elections in late 1991. The last year of this period (1999), however, was less closely investigated because it was also the period during which the initial analyses of this study were being undertaken. In addition, the study looked at policy debates in the late 1980s so as to understand the roots of post-1991 policy development.

Table 2.1 outlines both the health care financing reforms that have been the focus of this evaluation and the parallel, institutional reforms that were considered in less depth.

Table 2.1. Reforms Covered in the Study

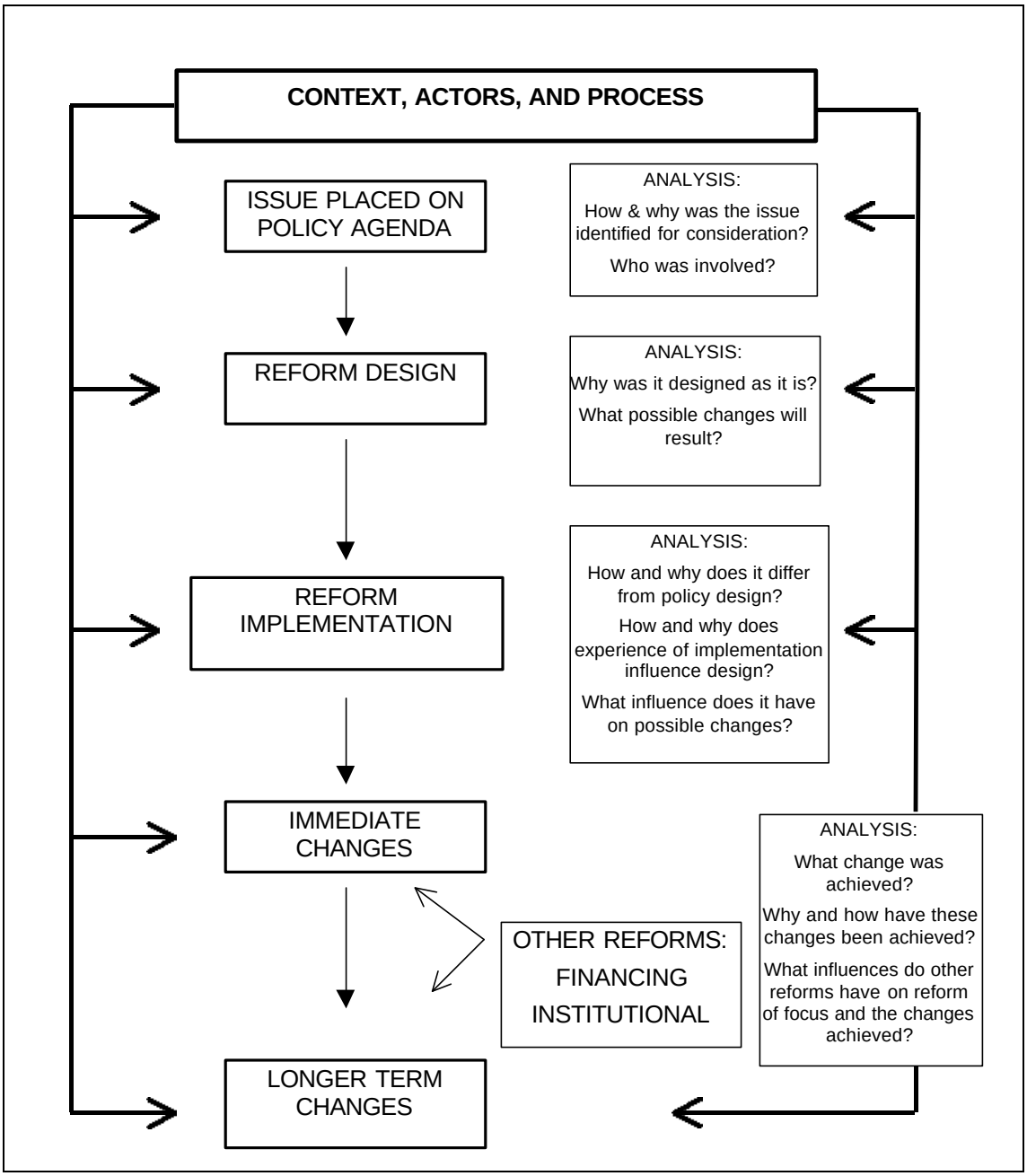
Type of Reform	Specific Reform
Resource mobilization	Formal introduction/expansion of user fees throughout the public health system
	Introduction of prepayment
	Development of exemption policy
Resource allocation	Development of inter-district resource allocation formulae
	Budgetary reform to reallocate resources between levels of care
Parallel, institutional reforms	Strengthening of the district health system with formal autonomous boards
	Increased autonomy to referral hospitals

2.2 Conceptual Framework and Research Questions

The conceptual framework developed to guide this study is summarized in Figure 2.1. For conceptual clarification, the framework posits a linear process of policy change, moving from agenda setting around a reform of focus, to reform design, and then through implementation to the achievement of immediate and longer term changes. The framework's primary focus, however, is on a detailed investigation of what factors influence this apparently linear process and thereby, ultimately, shape the nature and extent of change achieved by the reform of focus.

In investigating these influencing factors, the framework points to the need to consider who or what causes an issue to be placed on the policy agenda and why specific reforms are designed in particular ways. It also allows for the nature of the reform to change through the process of implementation in unexpected ways.

Figure 2.1. SAZA Conceptual Framework



Drawing on the policy analysis approach of Walt and Gilson (1994), the framework suggests that the factors influencing each of the steps in the reform process can be categorized into four broad groups:

1. Factors of *context* (in turn derived from Leichter 1979):

   a) situational factors, i.e., the specific conditions of a moment in history that impact on the policy changes of focus (transient or impermanent conditions)

b) structural factors, i.e., the relatively unchanging circumstances of the society and polity such as the structure of the economy and the political system

c) cultural factors, i.e., the values and commitments of society as a whole and groups within it

d) exogenous factors, i.e., the events and values outside any one country or system that influence it

2. Factors concerning *actors*:

a) who they are as well as their interests, values, and roles in relation to the development and implementation of the reforms of focus

3. Factors of *process*:

a) the way in which the policies of focus are identified, formulated, and implemented, including issues of consultation, timing, and phasing

4. Factors of *content*:

a) the nature and design of the specific reforms of focus

b) the interactions between the different financing reforms of focus and between these reforms and the parallel institutional changes.

Overall, the conceptual framework highlights two sets of broad research questions:

1. Analyzing impact:

> What are the immediate consequences of the reform? Does it achieve its explicit objectives?

> What are the longer term consequences of the reform?

> What are the potential consequences of the reform given its design? Is it likely to achieve its explicit objectives?

2. Understanding the "policy process" as an influence over impact:

> How do factors of context, actors, process, and content influence impact through the reform design and implementation process?

> What factors determine the particular nature of the design of each reform and of the "package" of reforms being taken forward within a country?

> Does the practice of implementation influence the design of the reform? How?

> What factors explain how implementation practice differs from policy design?

> What factors explain the (potential) immediate and longer term consequences of the reform?

> What influence do other financing and parallel institutional reforms have over the reform and its consequences?

2.3 Overview of Research Strategy and Methods

2.3.1 Overall research strategy

Table 2.2 provides details of the key activities in each main phase of the research.

Table 2.2. Summary of Research Strategy

Phase	Key Foci	Data Collection/Analysis Methods
1	Delineation of key elements of reform context Description of chronology of key events in reform evolution Identification of key actors involved in reforms Detailed description of the design of the reforms of focus	Data collection: Capture of researcher's own knowledge Review of key policy documents and evaluation reports Data analysis through: Development of 'timelines' for each reform of focus
2	Detailed analysis of the factors facilitating and constraining the reforms of focus Assessment of the actual or, where relevant, potential impact of reforms	Data collection: Key informant interviews with informed and accessible policy makers, managers, donors, analysts, and technical advisors (TA) central to reforms in general or to specific reforms Limited media analysis Collection of secondary data for impact analysis Data analysis: Impact analysis through use of secondary data
3	Draft and finalize country reports	Data collection and analysis: The process of writing a draft report entailed further analysis, and a limited review process generated additional comments that were then incorporated into the final report.

An overview of key issues concerning the reforms of focus was undertaken in Phase 1, providing a foundation for the more detailed analysis undertaken in Phase 2. The information collected in this phase also allowed the analytical questions guiding analysis to be revised and fine tuned. Phase 2 then involved more detailed analysis of the key areas of focus, using a wider range of data analysis techniques and approaches and leading to a draft report. Finally, in Phase 3 the draft country report was developed and disseminated for limited review, comments were incorporated, and the report finalized.

2.3.2 Data collection and analysis methods

Table 2.3 provides detail on the data collection methods used in this study and the application of information derived from these methods.

Table 2.3. Details of Data Collection Methods Used

Data source	Details	Application
Phase 1		
1. Researcher knowledge	One member of the research team was interviewed concerning aspects of the policy processes of focus	Input across analysis, subject to validation through other data collected
2. Document review	Documents reviewed included: Contributions to, and reports of, policy debates pre-1991 Academic analyses of reforms pre- and post-1991 Official post-1991 policy documents and policy input papers Consultancy and evaluation reports on the reforms of focus	Understanding the context of reform Development of timelines for reforms of focus Identification of design details of reforms of focus
Phase 2		
3. In-depth interviews and use of email questionnaires	24 in-depth interviews: Two with current or former politicians; Eight with national government officials (health and non-health, current and former); One with a district health official; Six with external technical advisors, all of whom were long-term (i.e., one year or more) and one of whom was based at district level; Four with other Zambian officials – academics and nongovernmental organization (NGO) staff; and Three with representatives of donor agencies (one multilateral, two bilateral). In addition, email responses to a short questionnaire were obtained from one former Ministry of Health (MOH) official, one long-term TA, one short-term TA, and one advisor with long-term involvement from an overseas base.	Understanding the context of reform Development of timelines for reforms of focus Identification of design details of reforms of focus Understanding of specific processes around design and implementation of the reforms
4. Media analysis	Review of health issues coverage in two Zambian newspapers: The Times of Zambia , and The Post.	Understanding the context of reform Some use in policy characteristics and stakeholder analyses
6. Published evaluations	As part of document review	Assessing impact of the cost-sharing policies and potential impact of resource reallocation policies

7. Secondary data	Government budget and expenditure data Health facility utilization data	for additional evaluation of the impact of resource re-allocation policies To assess the impact of cost sharing
Phase 3		
8. Report review process	The draft report was reviewed by one former Zambian Central Board of Health (CBOH) official, one member of the South African team, and one international reviewer.	Input into all aspects of report

As Tables 2.2 and 2.3 indicate, the study combined use of qualitative and quantitative methods of evaluation. Qualitative approaches were largely used in assessing the factors facilitating and constraining the reforms of focus, and quantitative and qualitative methods were combined in analyzing the actual and potential impact of these reforms.

The first step in the study was to capture the important knowledge of the reforms and related processes held by one member of the research team who had been involved in policy development prior to the study. The explicit aim was to identify her understanding and perspectives independently of other data collection efforts, allowing her views then to be tested and validated through other data collection methods.

A full document review aimed to analyze as much relevant documentation as possible. Document selection was based on importance across the reforms of focus, ability to provide an historical perspective, and accessibility. A generic framework was used to guide the document reviews and ensure a common, but open, approach to analysis. Following review of a first set of documents, an initial coding structure was developed from consideration both of the information collected and the study's conceptual framework. The aim of this coding was to categorize the information collected through document review in relation to issues of relevance to the study. In practice this coding was not used fully, and individuals tended to develop their own codes for content analysis as the basis for the use of documentary data in subsequent analyses. Members of the research team then took responsibility for initial analysis of these data by generating the following:

> Timelines identifying the key steps in each reform's development and implementation

> Analysis of key, relevant factors of context and key actors directly involved in the reform

> Analysis of the detailed design of each reform.

In-depth interviews were conducted during phases 1 and 2. Interviewees were selected so as to include those who had direct involvement in reform development and implementation and to obtain the perspective of different groups (e.g., government officials, technical advisors (TA), and analysts and health officials outside government). In addition, earlier interviewees identified important people whom they felt should be interviewed as part of a later group. The interviews were open-ended, although a series of broad guiding questions was developed for use within them, and adapted appropriately to specific interviewees. Either the interviews were taped and transcribed, or detailed notes were taken and typed up following the interview, using the tape as backup where possible. Only one respondent refused to be taped. Each interview was then coded, broadly using categories derived from consideration of the information collected and the study's conceptual framework.

Members of the research team then analyzed these data by reform of focus and by the four broad factors likely to influence their evolution. Such analyses supplemented those undertaken through document reviews, adding more detail to the understanding of specific aspects of policy formulation and implementation, and to the role of different actors.

To supplement the document review and interviews, a media analysis was undertaken. This analysis, however, only partially considered the influence of the media over policy debates, and served more as an additional documentary source of information. One government and one independent paper were reviewed.

Finally, data drawn from published evaluations and additional analysis of secondary data allowed assessment of the impact of the user fee and resource allocation reforms already implemented, as further explained in Section 2.4.

2.4 Assessing Impact

The study's assessment of the impact achieved by the reforms of focus has four components. It seeks to understand the impact of reforms on equity and sustainability, while at the same time, it considers any additional impacts of the cost sharing and resource allocation reforms actually implemented in the period of focus (1991-1999).

The focus on equity is clearly of relevance in Zambia given the government's recognition of the imbalance in service availability and accessibility between urban and rural areas (MOH 1992a: i; interview data). The specific objectives of the reforms of focus also highlight the importance of equity as an objective by which to assess their impact (see Table 2.4). Equity is understood in this study as requiring consideration of the distribution of the benefits and burdens of health care and of the procedures by which those distributional decisions are made. The latter concern reflects a growing emphasis on procedural justice within an understanding of equity as, for example, applied to resource allocation debates (e.g., Mooney 1996; Mooney 1998). This concept of strengthening public participation in health services development has been explicitly recognized as a core element of change in the Zambian context (Kalumba 1991; MOH 1992a: iii).

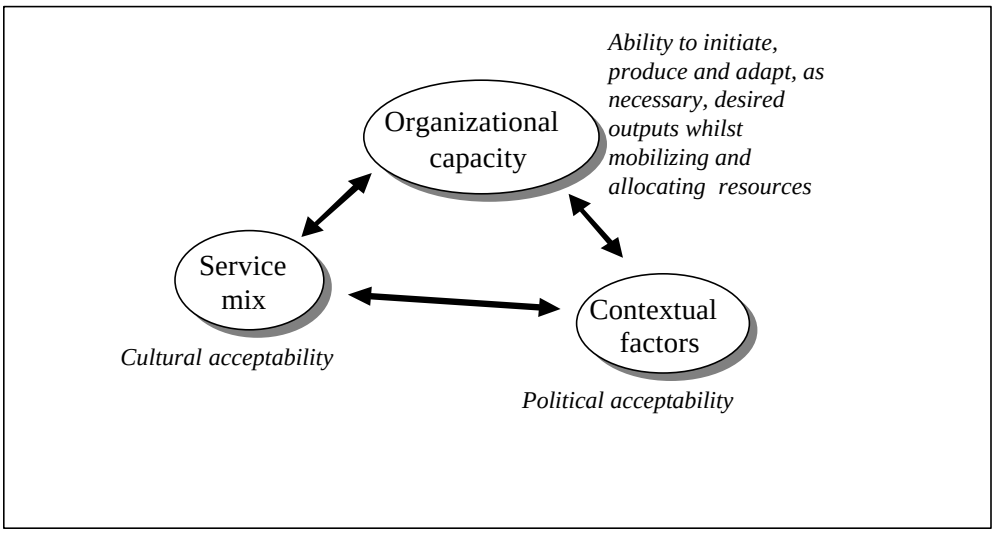
Table 2.4. Stated Objectives of Financing Reforms of Focus

Stated objective	Classification according to impact area	
	Equity	Sustainability
Introduction/expansion of user fees		
To generate additional resources		(✓)
To foster partnership between users and the health system	(✓)	(✓)
Introduction of poverty-related exemptions (as a pilot)		
To remove financial barriers to access for the poorest in society	✓	
Introduction of prepayment in urban districts		
To improve financial access to health care for Zambians (though restricted in practice to those selected districts)	(✓)	
The Ministry of Health's resource reallocation formula		
To distribute financial resources equitably between districts	✓	
Budgetary reform		
To shift resources away from higher level services towards primary health care	(✓)	(✓)

Notes: bracketed ticks indicated an objective implicit in policy documents rather than one explicitly stated.
Sources: MOH (1992a), MOH (1993), MOH (1995), MOH (1996) MOH (1998a)

Table 2.4 also points to the relevance of sustainability as a policy objective against which to measure impact. This study, however, has considered sustainability as a critical aspect of the pursuit of social justice. Like equity, sustainability has various aspects and includes consideration of financial sustainability, combining the mobilization of resources with improvements in allocative and technical efficiency, the political acceptability of reforms, and the organizational capacity of the system to develop and implement reforms over time. Olsen (1998) has, for example, suggested that a health service is sustainable when operated by an organizational system with the long-term ability to mobilize and allocate sufficient and appropriate resources (manpower, technology, information, and finance) for activities that meet individual or public health needs and demands. Figure 2.2 summarizes the key aspects of health system sustainability considered in this study.

Figure 2.2. Components of Sustainability



To facilitate impact assessment against the two broad goals of equity and sustainability, several specific criteria were identified. These criteria reflect the nature of the reforms of focus and the available data (see Section 5). The following criteria were used in assessing equity:

> Cost sharing – equal access/utilization for equal need

> Geographic resource allocation – equal budget/expenditure per head of the population between and within provinces (with some needs-based weighting)

The following criteria were applied in assessing sustainability:

> Resource mobilization levels and potential

> Allocative efficiency of resource use

> Contribution of reforms to strengthening the health system's "organizational capacity" (involving consideration of human resource availability, management systems, the networks of organizations involved in implementing a specific task, and the broader institutional environment of these organizations. [Hilderbrand and Grindle 1994].

2.5 Ensuring Rigor and Validity in Interpretative Analysis

In analyzing this study, the research team has had to interpret the information it has collected to make a variety of judgements concerning the actual and potential impact of the reforms of focus and the factors that have influenced their evolution and impact. Such interpretation cannot be avoided in a study of this kind, and a variety of strategies have been adopted to bring rigor and promote validity in the interpretative judgements that have been made.

These strategies included the following:

> Involving both "insiders" (researchers with detailed knowledge of the policy processes) and

"outsiders" (researchers with previously less involvement in the policy processes) in the study process

- Developing and testing specific guidelines for review of all forms of documentation (including media analysis) and for in-depth interviews based on the study's conceptual framework and their initial application

- Incorporating two steps of triangulation in data analysis: first, involving triangulation between information derived from different documents, interviews, and media reports; and second, involving triangulation of information derived from these different sources of data

- Reviewing the process for successive drafts of the report sections, initially done by members of the South African research team, and subsequently done by allowing analyses to be tested against the judgments and views of selected key informants who have played a central role in relation to the reforms of focus.

The process of data collection and analysis has been an iterative process, as summarized in Table 2.5. This process has explicitly required the research team to develop and refine interpretations and analyses, repeatedly testing individual researcher's judgements against those of other team members and, ultimately, against those of the key informants involved in the final report review process.

Table 2.5. Key Iterations in Analysis

Study Activities	Steps in Analysis and Interpretation
Joint SA/Zambian team workshop 1 (October 1997): Development of conceptual framework and overall research strategy	
Jan – March 1998 data collection Phase 1	Initial analyses: timelines, design details, contextual factors
Joint SA/Zambian team workshop 2 (March 1998): Review of initial analyses	
March – November 1998 data collection Phase 2	Further analyses, including development of first input papers on each reform of focus; development of input papers on factors of context, actors, processes, and design across reforms of focus
Zambia team workshop (Dec 1998): Continued development of input papers	Preparation of preliminary analyses
Joint SA/Zambian team workshop 3 (January 1999): Review of preliminary analyses	Continued data collection, analysis, and preparation of first draft sections
Presentation to UNZA colleagues (February 1999)	Input into analyses
Visits to Zambia by South African research team members (April, May 1999)	Ongoing preparation of first draft sections
Review of first draft sections by research team members and one international external reviewer (Oct 1999)	Preparation of draft two report sections
Presentation of preliminary findings to MOH/CBOH colleagues and external advisors (Nov 1999)	Input into second draft sections
Review of second draft sections by external review team (March 2000)	Input into final draft sections
Report finalization (April 2000)	

2.6 Use of Data

This report presents the research team's final interpretation of health care financing reform experiences through the overall process of data collection, analysis, and interpretation described above. It gives particular weight to the qualitative interview data that provide most insight on the central issues of the study – that is, the factors shaping the pattern and pace of reform, and their

influence over impact. These interview data both underlie the interpretative analysis presented in the report and are used directly (as specific quotations) to illustrate particular issues and perceptions. Where possible, documentary data have also been used to supplement insights derived from the interview data, as referenced in the report. It is important to note that the specific quotes used in the report have been deliberately selected either because they provide an example of a view commonly expressed or because they reflect the view of a particular and important actor group. In presenting these quotes, the anonymity of the respondents is preserved, although, wherever possible, the respondent category (see Table 2.3) is identified.

Finally, the analysis of reform impact combines use of the research team's own analysis of available secondary data, published evaluation studies and their conclusions, as well as some interpretation of experience derived from interview data. Again the quotations used in this analysis have been deliberately selected for the same purposes outlined above.

2.7 Remaining Methodological Concerns

Despite the careful research process, four specific issues do influence the interpretative analysis presented in this report.

2.7.1 The Focus of the Study

During analysis of the information collected in this study it became clear that the focus on financing reforms has given the study a particular and partial perspective on the overall process of health policy change in Zambia in the period 1991-1999. As mentioned in Section 1.3, decentralization has formed the cornerstone of the Zambian reform package, yet it has not been reviewed here in detail. This analysis is therefore shaped by focus on a different set of factors. These particular financing reforms have, to some extent, involved a different range of actors and groups than the other health sector reforms. Although this study provides an insight into the broader process of health sector "transformation," it does not give a full view of that process. For example, rather than only considering issues of implementation at district level and below, it retains a clear focus on issues of policy development and the national level because of the pattern of reform evolution in relation to both interdistrict resource allocation and cost sharing.

2.7.2 Researchers as Past Participants in Policy Processes

Recognizing the role of one research team member in past policy processes, specific efforts were made to limit her potential influence over analysis and interpretation. This report, therefore, presents as far as possible the interpretation and judgements of the research team as a whole and not of specific members within it. The potential remains, however, for research team members' personal experiences to have colored their judgements. Such experiences include not only direct involvement in past policy processes but also the continuing involvement of all team members in policy action and evaluation, given the strong links between the Department of Economics at the University of Zambia (UNZA) and the MOH/CBOH.

2.7.3 Interviewee Balance

Although efforts were made to ensure that those interviewed represented a balance of different perspectives, a higher proportion of central government officials, past and present, were interviewed than of nongovernment observers, analysts, and managers at the operational level. Although nongovernmental views were obtained by interviewing technical advisors and representatives of donor organizations, these are also likely to reflect a bias towards central level perspectives.

2.7.4 Interviewee Access

The interviewee balance itself reflects some problems in accessing pre-identified government and political interviewees. Most importantly, it proved impossible to arrange interviews with either the current Minister of Health at the time of the study, one of her predecessors during the period of focus, or of the current permanent secretary in the MOH. In addition, various constraints meant that anticipated field visits were not made, and there was therefore insufficient inclusion of the perspectives of implementors at the district level and below.

3. The Context of Health Financing Policy Development in Zambia

3.1 Introduction

An analysis of health financing reforms in Zambia must be situated within the political and economic context of the country. As such, this section outlines some of the key aspects of Zambia's history that have impacted upon the development of health financing policy. The nature and extent of this influence is addressed further in Section 7.

Section 3.2 looks at Zambia's historical background and attempts to show how the political and administrative structures have shaped the present day structures, including the health sector. Section 3.3 discusses the declining economic situation that stimulated discussion of alternative financing mechanisms and explains the substantial donor involvement in the health and other sectors. Section 3.4 outlines the demographic, poverty, and epidemiological profiles of Zambia, while Section 3.5 concentrates on the health sector and provides a broader picture of the current reforms. Section 3.6 summarizes key contextual factors.

3.2 Historical Background

3.2.1 From Independence to the Third Republic

Zambia's colonial history covers two main periods: pre-colonial, prior to1890; and British colonial rule, from 1890 to 1964. The period between Independence and the present day also embraces three major phases of Zambia's political and administrative development. These periods are known as the First Republic from 1964 to 1972, the Second Republic from 1972 to 1991, and the Third Republic from 1991 to date.

Copper was discovered in the 1920s, leading to the establishment of mining companies that demanded large numbers of laborers. This resulted in male migration flow from rural areas to the present day Copperbelt. Consequently, this led to the impoverishment of the rural areas and the development of an urban pattern of settlement along the line of rail, which still exists today. The growth of the mining industry also encouraged agricultural development along the railway, which was needed to feed the workers on the Copperbelt and the expanding population immediately surrounding it. The remainder of the country remained poor. In short, the copper boom did not necessarily benefit the rural economy.

The period from 1953 to 1963 saw the existence of the Federation of Northern Rhodesia, Southern Rhodesia, and Nyasaland. During this period, government was controlled from the capital of Southern Rhodesia, Salisbury (known today as Harare). The federal arrangement was generally unpopular among Africans and led to the intensification for independence among the respective territories.

Zambia attained self-government in 1963, and in October 1964 became an independent sovereign country, with Dr. Kenneth Kaunda as the country's first president. According to Tordoff (1974), Zambia inherited from the colonial government a fragmented administrative structure consisting of a collection of departments that enjoyed great autonomy. These departments were not tightly controlled from the center, and hence it was difficult for the new government to then reorient these administrative structures so that they became instruments of development.

The country was divided into nine provinces, each headed by a deputy minister appointed by the president. Each province was, in turn, divided into districts, of which there were 44 by 1968. A district secretary, who was a civil servant, was in charge of a district. The administrative reforms of 1969 placed a cabinet minister in each province supported politically by a minister of state, governors, and permanent secretaries. This reorganization was intended to mobilize the rural economy and enhance development. Others regarded this, however, as the start of a process of politicization of the administrative structures (Tordoff 1974).

During this period Kaunda's agenda was to raise standards of living, achieve a more equitable distribution of wealth, improve the working conditions of workers, and maximize social security by providing free health services and expansion of educational facilities. Other priorities included promoting trade, industry, and agriculture in the country. To achieve these objectives, successive National Development Plans (NDP) were developed, although implementation was limited. Among the goals the first NDP (1966-70) aimed to achieve were:

"improvement of rural standards of living, diversification of the economy, reducing the imbalance between rural and urban sectors through more equitable allocation of investment funds, and policies to encourage education and health of the broader masses." (Government of the Republic of Zambia (GRZ) 1966: 2-4)

Despite this reform effort, the government was not immune to problems. At independence Kaunda and his cabinet colleagues had no experience in running the country and the political system on a national scale. Inevitably, they had to rely heavily on the inherited colonial civil service and advisors. Another problem was that ill feelings existed among certain ministers due to their lack of experience.

Politically, the period nearing the end of the First Republic was plagued with heightened political tension and conflict between the United National Independence Party (UNIP) and the opposition parties, the African National Congress led by Harry Mwaanga Nkumbula and the United Progressive Party led by Simon Mwansa Kapwepwe. Subsequently, following a commission of inquiry set up in February 1972, the one-party state system was introduced in Zambia. Kaunda's justification was that the one-party system would enhance the vision of participatory democracy and that it would enable energies to be focused on development instead of being dissipated in factional conflicts (Tordoff 1974).

The Second Republic came into being in December 1972, with the one-party participatory democracy now the adopted political system and UNIP at the helm. The strong constitutional position of the president in this system enabled him to determine personally the broad outline of major policies and to make many important decisions. The UNIP national council was the highest policy-making body taking precedence over all other political and administrative structures. The major instrument used to guide development during the early part of this period was the Second National Development Plan (1973–1977).

The Third National Development Plan was implemented in 1979 and ran up to 1983. Following the adoption of a Structural Adjustment Program (SAP) under the auspices of the International Monetary Fund (IMF)/World Bank (WB) at the end of this period, consumer-based subsidies were removed by government in November of 1986. Soon after "divorcing" the IMF in 1987 but then accepting IMF conditions in 1989, the Government of Zambia together with the IMF came up with a Policy Framework Paper (PFP), which coincided with the commencement of the Fourth National Development Plan. The main prescriptions of the PFP included phasing out subsidies; eliminating the national budget deficit; liberalizing trade, privatization or closure of loss-making parastatals,[1] and reducing inflation to 15 percent by 1992 (GRZ 1989).

During the early 1990s, the world was seeing heavy criticism of one-party systems. Pressure mounted in Zambia, especially when UNIP implemented the prescriptions of the PFP. In particular, the increase in the maize meal price by more than 100 percent in June 1990, due to the reduction of subsidies, sparked violent riots, which left 26 people dead. The riots culminated in an attempted coup by Mwamba Luchembe, a junior army officer. This served to further increase pressure against the one-party regime. The fight against the one-party system gained even more impetus with the formation of the Movement for Multi-party Democracy (MMD) in May of 1990. Although initially a pressure group, MMD evolved into a political party and represented a coalition of various social forces such as businessmen, trade unionists, religious leaders, student organizations, old ex-UNIP politicians, and academics from the University of Zambia. Some people felt that, because of this diverse background, the MMD would not hold as a political party (Banda et al., 1994). However, following Kaunda's repealing of article 4 in October 1990 (the article that legally established the one-party state) and the general elections of October 31, 1991, the MMD, led by Frederick Chiluba, emerged the winner via a landslide victory. This was a historical moment that gave birth to a new political era in Zambia called the Third Republic.

3.2.2 The 1991 Elections and the Third Republic

Chiluba, former trade unionist and now the MMD leader, won 76 percent of the popular vote in 1991 and overshadowed Kenneth Kaunda, the incumbent. The National Assembly vote was equally resounding. The MMD obtained 74 percent of the vote and won 125 out of 150 seats in parliament. The other 25 seats went to UNIP as the opposition party. UNIP was swept out of office. As Lumbwe (1995) writes, *"the margin of the party's defeat in every region of the country except the Eastern Province was devastating. On the Copperbelt province, the UNIP president obtained a bare 9 percent of the vote. His outright victory, however, was recorded in the Eastern Province."* Elsewhere, though, the MMD simply overwhelmed UNIP, as can be observed from Table 3.1.

[1] Parastatals are companies that were largely formally nationalized, but are now nominally independent of government. They tend to benefit from substantial government subsidy and often, in practice, experience interference in their management. They are generally located in key industries such as transport and the primary sector. Many have been closed or privatized since the change of government.

Table 3.1. Valid Votes Cast in the 1991 General Election for President

Provinces	Votes	Chiluba	%	Kaunda	%
Central	99,930	74,355	74.40	25,575	25.59
Copperbelt	299,337	271,252	90.62	28,085	9.38
Eastern	171,444	44,483	25.95	126,961	74.05
Luapula	93,228	83,039	89.07	10,189	10.93
Lusaka	168,175	128,709	76.53	39,466	23.47
Northern	140,723	119,685	85.05	21,038	14.95
North-Western	66,891	46,950	70.19	19,941	29.81
Southern	150,888	128,589	85.22	22,299	14.78
Western	92,357	75,150	81.37	17,207	18.63
ZAMBIA	1,282,973	972,212	75.80	310,761	24.22

Source: Lumbwe (1995:14)[2]

The story was much the same in the National Assembly. Except in the Eastern Province, where UNIP had 74 percent of the vote, the party's performance was poor (Lumbwe 1995:14-15). Thus, this election was really a "revolution" against Kaunda and the one-party rule. Given the size of the victory, it is not surprising that some people felt that it led to a de facto one-party system. *Newsweek*, for example, described the situation as a multiparty system with one-party supremacy (September 1994).

Despite these misgivings, however, the Third Republic was ushered in amid an atmosphere of high expectations. It was as if the change in government would also automatically transform people's lives overnight. The new government set off by first announcing and then rapidly implementing bold macroeconomic reforms. Reforms were the main agenda and were vigorously and enthusiastically pursued in key sectors such as agriculture, health, and education and in the civil service. In addition, major institutions such as the Bank of Zambia and the Ministry of Finance (MOF) were restructured. Other institutions like the Zambia Privatization Agency and the Zambia Investment Centre were created so as to facilitate the shift to the market-oriented type of development pursed by the MMD.

At the government level, the 1991 constitution still provided for a strong executive president assisted by cabinet. The multiparty parliament replaced the one that had been obtained in the Second Republic. Institutions such as the Anti-Corruption Commission and the Drug Enforcement Commission were, at least in theory, further strengthened by giving them wider powers of prosecution. The president still retained strong powers to appoint, reshuffle, and dismiss cabinet ministers.

With respect to local government, the 1991 Local Government Act number 22 replaced the 1980 act. The Act brought back the mayoral system while discarding political portfolios such as district governors, district secretary, district political secretary, and provincial political secretary. The Act provides for the president to appoint a deputy minister and a provincial local government officer for each province.

[2] Figures obtained from Zambia Elections Office (1992) 1991 Presidential and Parliamentary Election: Final Official Election Results

Having barely settled in government, accusations of corruption and drug trafficking surfaced against some ministers in 1993. At the consultative group meeting in Paris, France, in December 1993, the donors made it clear that they would not release further aid *"unless the government deals effectively with high consumption and drug trafficking in high office"* (Times of Zambia, December 11, 1993). This led to the resignation from government of MMD founder members Vernon Mwaanga, Nakatindi Wina, and her husband and deputy speaker at that time, Sikota Wina. These allegations dented the reputation of the new government, leading many to begin to doubt the government's credibility.

On the policy side, some of the policies the government had eloquently articulated were not working as planned. The Public Sector Reform Program (PSRP), whose original goal was to reduce the size of the nonmilitary public service from 136,775 to 80,000 persons by the end of 1999, lacked the necessary financial support for full implementation, for instance. Privatization had its own consequence of job losses, and some other companies were closing down due to the austerity measures leading to an enlargement of the informal sector. Other reforms such as the agricultural sector investment program have been described as a *"complete, utter and costly failure"* (Profit Magazine, January 1995). The failure in agriculture was directly linked to the government's policy of withdrawing subsidies and liberalization of maize marketing. In the 1993/94 farming season, farmers were given promissory notes rather than cash for their produce. This resulted in controversy, as farmers had to wait too long before they could convert the notes to liquid cash.

Perhaps the major controversy came with the passing of the 1996 constitution, which contains a clause stating that, to qualify, a presidential candidate must be born of parents who are Zambian citizens by birth or descent. This provision was perceived as being designed primarily to prevent Kaunda from contesting the presidency, and the bill was heavily opposed both in parliament and outside. UNIP members of parliament walked out in protest, and university students, among others, demonstrated their opposition. By now the donor community was becoming impatient with Zambia's governance issues. Other contentious issues were the adoption of the 1996 constitution and the 1996 voters' registers. The MMD insisted that the constitution was adopted solely by parliament, rather than by a broader based assembly, while the registers were alleged to have a number of irregularities, such as the omission of thousands of voters and incorrect coding. UNIP expressed outrage at these incidents and ultimately boycotted the November 1996 elections. MMD won with 131 seats in parliament, 19 seats being won by UNIP and one seat by an independent.

An alleged shooting of Kaunda at a Kabwe UNIP rally in 1997 further incensed donors, who reacted by announcing a freeze on aid. The impact on the economy was severe. Balance of payments (BOP) problems worsened, and some reform programs such as the PSRP had to be put on hold. Still other development projects could not be implemented.

Allegations of corruption also continued into 1997, and in October of that year, Zambians woke up to a rude shock when junior army officers announced on radio that they had taken over the government. The coup, led by the so-called "Captain Solo," was promptly crushed. Immediately thereafter, Dr. Kaunda (UNIP), Dean Mung'omba (leader of Zambia's Democratic Congress (ZADECO)), and Nakatindi Wina (MMD) were arrested and charged with prior knowledge of treason regarding the attempted coup. The international outcry that followed resulted in another donor aid squeeze that further affected Zambia's economy. Kaunda was released from house arrest in June 1998 on the condition that he retire from politics, while Nakatindi Wina and Mung'omba remained in jail until the end of 1998, when they were released without charge.

In November 1998 a new opposition party, the United Party for National Development, was launched under the leadership of Anderson Mazoka, the former managing director of Anglo

American Corporation in Zambia (The Post, November 30, 1998). More generally, however, there was evidence of widespread apathy among the Zambian electorate, with both a poor response to the voter registration exercise that year and a low turnout in local government elections (Department for International Development (DFID) 1999).

3.3 Continued Macroeconomic Decline

Zambia joined the ranks of those officially designated as "low-income countries" in 1991. Currently, it is one of the poorest countries in the world with 1998 World Bank estimates of per capita gross national product (GNP) at US $330, down from $370 in 1995. The economy has mainly depended on one commodity, copper, since it began exporting copper in the early 1930s. In the 1980s, copper was estimated to account for more than 30 percent of Zambia's Gross Domestic Product (GDP) and over 95 percent of foreign exchange earnings (Freund 1986). More recently, World Bank estimates show that copper accounted for 51percent of the value of exports in 1998, down from 56 percent in 1997 and 85 percent in 1987 (http://www.worldbank.org/data/countrydata/aag/zmb_aag.pdf).

3.3.1 Economic Mismanagement and the Legacy of the UNIP Government

In the years following independence, the economic policy pursued by government followed a socialist path to development. Government revenues generated from copper sales were used to expand social services like education and health. Civil service employment also expanded. Wages for African workers in the mining sector were brought up to the levels of whites, while government workers were paid equivalent amounts.[3]

The early years after independence saw the government commit itself to a mixed economy, with an open attitude toward foreign investment. However, this soon changed with the Mulungushi Declaration in 1968 and the Matero reforms the following year. These reforms greatly expanded the state's role in the economy with government assuming majority shares in existing enterprises and creating new ones. By the end of the 1970s, an all-embracing system of controls had developed, with price controls for major commodities. The government intervened in the credit allocation system through the Zambia National Commercial Bank (ZANACO). Import controls that were introduced when foreign exchange became scarce after 1975 were further enhanced, while an overvalued exchange rate with consequent foreign exchange rationing was introduced. State ownership expanded into many parts of the manufacturing sector, into agricultural marketing, and into the important mining sector.

Although the mines were the second largest employers after government, the copper boom, as Freund (1996) has argued, soon became a copper curse, and dependence on one major export resulted in a deepening economic crisis (MOH/ World Health Organization (WHO)/ United Nations Children's Fund (UNICEF)/WB, 1996). Freund (1996) attributes this economic decline to external

[3] A number of sources provide extensive economic background; for example, White and Edstrand (1994: section 2) and Adam et al. (1994: section 7).

and internal factors. External factors emanated from the world recession of the early 1970s. This was further hampered by unfavorable terms of trade plus the decline in world copper prices. Internal factors, on the other hand, increased labor costs and directly affected the mining sector in terms of increased cost of production. The country's balance of payments position worsened while the foreign reserves dwindled, leading to increased import prices, increased debt burden, reduced government revenues, and the devaluation of the local currency.

In the early 1970's, copper prices fell drastically to their lowest levels since 1945. This situation was further compounded by the world economic recession that resulted from the oil crisis. Consequently, the Zambian economy entered a long period of stagnation and rapid decline. Freund (1986) and Mahler (1997) write that between 1965 and 1974 real gross domestic product grew at an annual rate of 2.3 percent, but that since 1974, the country did not experience growth (except briefly in 1988). Coupled with high population growth, the GDP continued to decline steadily so that by 1983 it had fallen to 45 percent of its 1965 level (White 1994). Because of shrinking foreign exchange reserves induced by unequal exchange rates and poor terms of trade, the country increased external borrowing to finance the current account deficit. These funds, however, were used to finance real consumption levels at the expense of investments – the consumption rate, for example, rose from around 60 percent to over 80 percent with the investment ratio falling from more than 30 percent to less than 20 percent (White 1994).

Borrowing continued against the prospect of future copper earnings so that the debt burden grew steadily from around $0.8 billion in the early 1970s, to $2.5 billion in the late 1970s and up to $7.0 billion by the 1990s (op cit). As a result, debt service obligations mounted heavily. In 1974 debt service obligations were equivalent to less than 8 percent of export earnings; by 1983 they consumed 52 percent of the export earnings. In addition, accumulated external overdue payments totaled over US$1 billion (The Monitor, 1998). However, even with strong financial policies, the avoidance of nonconcessional borrowing, and the full use of traditional debt relief mechanisms, Zambia's external public debt burden would still not reduce to sustainable levels before the middle of the next decade. According to the PFP for 1998-2000, the baseline scenario indicates that the ratio of the net present value of debt to exports, which was estimated at 414 percent at the end of 1996, will remain above 250 percent until 2004 and will not fall below 200 percent until 2006. Debt service after rescheduling will not fall below 25 percent of exports of goods and services until 2003, and it will then still be equivalent to about 35 percent of government revenue and 30 percent of expenditures. Because of this immense pressure, Zambia is likely to fail to meet its debt service obligations and has had to give in to austerity programs to obtain IMF rescheduling. In essence this means that Zambia has had to implement structural adjustment programs, including Kwacha devaluation, price controls, wage freezes, and the removal of government subsidies on essential commodities. Zambia first made recourse to the IMF in 1973, and four additional IMF agreements were made in the period up to February 1986.

During 1985, Zambia launched a World Bank-supported program that involved wide-ranging macroeconomic and structural reforms. Domestic financial policies were tightened and market determination established for the exchange rate through the auction mechanism. Although the auctioning of foreign exchange accounted for only one-fifth of the total foreign exchange transactions, the market determined rate was taken as the official rate. This resulted in a substantial depreciation from K2.2 per dollar before the auction to a peak of K21 per dollar before the system was suspended (National Commission for Development Planning (NCDP) 1988:2). The auctioning system was abandoned as it was thought to be responsible for high inflation and for allowing the rich to benefit from luxury imports.

In 1986, controversy erupted with riots flaring up on the Copperbelt. This was in protest to the planned removal of subsidies on the staple food maize. Had the subsidies been removed, the price of maize would have doubled. The government backed down, paving the way for the formal abandonment of the IMF program in May 1987. The Kwacha was fixed to a revalued rate of K8 to the dollar, and an administrative allocation mechanism, the Foreign Exchange Management Committee (FEMAC), was introduced.

The New Economic Recovery Program (NERP) was introduced during the same period. This represented a major shift in economic policy. NERP objectives included growth through diversification, reduced dependence on imports, and stabilization through the control of inflation. This particular objective was to be met through the rationing of foreign exchange through FEMAC. The government also reintroduced price controls and gave emphasis to recovery through the "use of own resources" (NCDP, 1988:2).

NERP appeared to have achieved something. In 1988, economic performance was strong. A growth rate of 6.7 percent was recorded, compared with growth of 2.2 percent in 1987 (NCDP, 1988). The contributing sectors to this growth were agriculture and manufacturing, which recorded 21 percent and 15 percent, respectively. Gross international reserves of the Bank of Zambia increased by Special Drawing Rights of 38 million. Export receipts also rose by 20 percent as a result of the copper price increase, while import demand was constrained by strict foreign exchange allocations.

During the first half of 1989 the Zambian government implemented some reforms, which included a coupon system to reduce the cost of food subsidies, a 63 percent devaluation, and decontrol of many prices. This set of reforms became the prelude to the resumption of talks with International Financial Institutions (IFIs) in September 1989. Relations between Zambia and the IFIs normalized in March 1991 with the clearance of arrears (which was achieved with substantial donor support) and the resumption of the suspended Economic Recovery Credit. By the 1990s, a comprehensive reform regime had been established.

3.3.2 Market-type Reforms

When the MMD came to power in late 1991, the general mood at that time was one of change and reform. As one technical advisor pointed out, *"Around 1990 people in Zambia were supporting almost any change as 'things couldn't get worse.'"* It was therefore relatively easy for the new government to push forward its broad reform agenda. In addition, because Zambia was seen as a successful example of transition to multiparty democracy, the donor community was also sympathetic towards the new government and provided support in terms of finance and technical assistance to aid the overall policy reforms. Hence, the MMD used its popularity as an impetus for implementing bold austerity measures, some of which could not have been implemented by UNIP during its time.

The Zambian government made dramatic changes in relation to liberalization of prices of commodities, credit, and foreign exchange. In 1989, the exchange rate had been overvalued and allocated through state machinery—a system that was described by the World Bank as inefficient and unjust. By 1995, foreign exchange transactions were conducted via an open market, with a market-determined exchange rate. The high inflation that had plagued the country in the late 1980s continued into the 1990s, although this was checked by the introduction of the cash budget and issuance of government stocks at the start of 1993. Price controls and consumer subsidies were removed on all products, most prominent among these being the fertilizer subsidy to farmers and the maize meal subsidy to consumers. State enterprises were also cut off from state support, e.g., Zambia Airways,

which, according to White (1996:6), received a subsidy that reached 1 percent of GDP in 1993—an amount equal to over $200,000 per employee. This eventually led to the liquidation of the company.

However, despite this ambitious reform program, the Zambian economy did not improve. Negative economic growth was registered during 1991-1995. With a population growth of about 3 percent, real per capita GDP declined by more than 20 percent during this period (Government of Zambia, 1998). In 1996, due to a good maize harvest, real GDP growth recovered to about 6 percent. This, however, could not be sustained, and the growth rate declined to 3.5 percent in 1997 and, according to the declarations of the finance minister, to 0 percent in 1998 (The Monitor, 1999). Inflationary pressure also continued to be a problem. The rate of inflation was 35 percent in 1996, 18.5 percent in 1997, and 30 percent in 1998. Copper production has been extremely low, and this has been worsened by delays on the sale of the copper mining parastatal, the Zambia Consolidated Copper Mines (ZCCM) (Government of Zambia, 1998). This situation was further exaggerated by lower copper demand as a result of the Asian financial crisis in 1998. Losses of about US$1.5 million per day have been estimated. Further, export earnings, government revenue, and government expenditure have declined over the period 1991 to 1996. Table 3.2 shows selected economic indicators for Zambia over the period 1991 to 1996.

Table 3.2. Economic Performance in Zambia, 1991–1996

Indicator	1991	1992	1993	1994	1995	1996
Per Capita Income at Constant $	405	364	358	291	278	250
Growth Rate of GDP (%)	0.0	-1.7	6.8	-8.6	-4.3	6.4
Inflation Rate (%)	93	192	138	35	46	35
Budget Deficit (% GDP)	6.1	3.5	2.5	-	-	-1
Current Account Balance (m$)	-447.7	-117	-88	-185	-314	-491.4
Export Earnings (m$)+	1.077	752	846	637	976	975
Imports (m$)+	801	837	809	588	787	-
Government Revenue (m$)+	643	659	588	742	534	394
Government Expenditure (m$)+	1,905	948	830	543	1105	906
External Debt Service Ratio as % of GDP	47.3	29.3	36.9	31.3	25.0	30.2

Source: Central Statistics Office, Quarterly Digest of Statistics, 3rd and 4th Quarter, 1996.
Selected Socioeconomic Indicators 1996, March 1997, Ministry of Finance, Macroeconomic Indicators (various issues).
+ Kwacha values were converted to dollars by using appropriate exchange rates.

Table 3.2 indicates that although GDP showed an increase in 1993 and 1996, and inflation decreased over 1991–1996, income per capita has consistently declined. As the economy has declined, the performance of the health and other social sectors has suffered.

Given the weak domestic resource base, the Zambian economy has remained dependent on external resources throughout the MMD government. However, at various times donor concerns have

led to such support being withheld. For example, donor pledges from the Consultative Group[4] meeting of March 1998 on BOP and project support totaling US$530 million were not released. This meant that for two years in a row BOP support was limited. In 1997 bilateral donors did not provide BOP support due to governance-related issues, such as the controversial 1996 constitution, which excluded persons whose parentage was not Zambian from standing as president. Other issues concerned the arrest of Kaunda and others suspected to be behind the failed coup of October 27, 1997. This outraged the donor and international communities, which in turn withheld their pledges to Zambia, exacerbating the country's economic problems.

3.4 Demographic, Poverty, and Epidemiological Profile

Zambia is currently ranked 151st out of 174 countries in terms of its Human Development Index (UNDP 1999), and comparison with the 1990 position shows a slight deterioration. This section outlines Zambia's current and recent position regarding population trends, poverty levels, and health status.

3.4.1 Recent Demographic Change

According to figures derived from the latest census in 1990, Zambia's population was as shown in Table 3.3.

Table 3.3. Demographic Profile of Zambia, 1990s

Indicator	
Total population (millions) 1996	9.5
Urban population as % of total population, 1995	38
Population growth rate (per annum)	
1969-80	3.2
1980-90	3.1
Sex ratio, 1990 (number of males per 100 females)	98
Population density (per Km^2)	
1980	7.5
1996	12.6
Dependency ratio	
Overall, 1996	89.0
Child (0-14years), 1995	82.5

Source: Central Statistical Office (CSO) (1996, 1997); GRZ (1996)

[4] The Consultative Group is a high level group of officials representing both the Zambian and donor government which meets regularly, generally in Paris, to review progress with economic and political reform, in relation to aid pledges and disbursements.

In 1990 the population of Zambia was 7,759,162, of which 50.5 percent were females and 49.5 percent were males, resulting in a sex ratio of 98.1 males for every 100 females. Population was projected to be 9.1 million in 1995, rising to 9.7 million in 1997 and to 10.3 million by the year 2000. The growth rate of the country's population was 2.6 percent per annum during the period 1963–1969, and 2.7 percent for the period 1980–90, but rose to 3.2 percent during the period 1969–1980 (Central Statistics Office (CSO) 1990).

The total fertility rate was estimated at 7.2 in 1980 while the 1992 Demographic and Health Survey placed the figure at 6.5 for the three years preceding the survey (Gaisie et al., 1993). The density of the population has progressively increased from 5.3 persons per square kilometer in 1969 to 7.5 persons per square kilometer in 1980 and 9.8 persons per square kilometer in 1990.[5]

3.4.2 Entrenched and Increasing Poverty

The per capita GNP of Zambia is so low that the country appears 180th in the World Bank ranking of 210 countries. The distribution of income in the country is highly skewed, with an estimated Gini Coefficient of 0.5 (Seshamani et al., 1999). According to recent surveys, poverty in Zambia is both widespread and worsening. An estimated 58 percent of the national population was said to be extremely poor in 1991 (World Bank 1994),[6] and this amount increased to 66 percent by 1996 (CSO 1997). An estimated 85 percent of the population is said to be living on less than US$1 per day (DFID 1999). This situation is more serious in rural areas, as shown in Table 3.4.

Table 3.4. Incidence of Poverty in Zambia (% Population), 1996

	Extremely Poor	Moderately Poor	Total Poor	Non-poor
Rural	79	10	89	11
Urban	44	16	60	40
All Zambia	*66*	*12*	*78*	*22*

Source: CSO (1997: 129)[7]

Sumaili and colleagues, (1996) also reported worsening poverty across the country and a general deterioration in the living standards of the people. The causes of this scenario varied from place to place. In rural areas, the situation was attributed to persistent droughts, especially in the southern parts of the country; frost in the western parts; and poor maize and input marketing practices. In urban areas, the main cause of poverty was rising unemployment,[8] which was due to retrenchments, lack of job opportunities for secondary school graduates and dropouts, and the declining access to education among children. This in turn has led to very low levels of human capital. In urban areas, low human capital has meant reduced household income-earning opportunities, which has impaired the population's ability to afford basic consumption and other social requirements. As a result, nutritional standards have fallen, making households more susceptible to disease. Low human capital in rural areas has led to declining agricultural productivity, hampering food production and

[5] These figures are obtained from the Zambia Human Development Report, 1997.
[6] The year for which the data was used in the 1994 Poverty Assessment.
[7] Poverty here is measured using adult equivalent income, and is therefore subject to the known concerns regarding measurement of household income through surveys.
[8] Formal employment rose from 362,000 workers in 1986 to a peak of 546,000 workers in 1992 and, thereafter, the trend turned downward, slowing to 472,000 workers in 1996. Unemployment remained high, and by 1996 had reached 15 percent according to the 1996 Living Conditions and Monitoring Survey (CSO 1997).

consequently leading to food insecurity and, ultimately, poverty. According to GRZ/UN (1996), poverty in Zambia can be described as a social crisis. Critical symptoms of this social crisis are worsening problems in public health and a decreasing life expectancy, often linked with the rising HIV/AIDS burden (see below). This situation is compounded by undernourishment, posing a greater risk to people's health by diminishing their ability to cope. This pressure has compelled many to adopt unhealthy lifestyles that further threaten their well-being. An estimated 70, 000 children live in difficult circumstances on the streets (GRZ/UN 1996).

In general, the effect of the declining economy has impacted across all sectors, although its implications are more serious in the social sectors.

3.4.3 Health Status and the Burden of HIV/AIDS

Despite impressive gains in the period following independence, key health indicators have worsened in Zambia over the past decade. Table 3.5 shows the current position relative to the region as a whole. The under-five mortality rate (U5MR) is considered to be a good measure of the well-being of a nation, but for the five-year period 1992-1996, U5MR was estimated to be 197 per 1000 live births, up from 174 per 1000 live births in 1982-86 (CSO 1996). This implies that almost one in five children born dies before his or her fifth birthday. Infant mortality declined from 125 to 80 deaths per 1000 live births in the first decade after independence, but it has recently climbed back to 113 per 1000. Similarly, life expectancy at birth has also been decreasing. After reaching a peak of around 54 years in the mid-1980s, it declined to 45.5 years by 1992 (GRZ/UN 1996). This is well below the average for sub-Saharan Africa. Much of this decline is attributed to poverty.

Table 3.5. Key Health Indicators

	Zambia[+]	**SSA***
Life expectancy at birth	43 years	51 years
Infant mortality (per 1000 live births)	109	104
Under-five mortality (per 1000 live births)	197	169
Underweight prevalence	23.5%	30%
Maternal mortality (per 100,000 live births)	649	975
Total fertility rate	6.1	-
[o]HIV prevalence (15-49 years old)	19.7%	-
AIDS cases (per 100,000 pop)	46.9*	11.2

Sources:
* UNDP Human Development Report 1998 unless otherwise stated
+ Zambia DHS (1996) unless otherwise stated
[o] MOH/CBOH (1999)

The onset of HIV/AIDS has compounded the already desperate situation. The National AIDS program reported 15,000 cases by 1991. In its quarterly digest of statistics, CSO (1996:38) shows that AIDS and AIDS-related conditions was the second major cause of mortality among adults in hospitals between 1993 and 1994, accounting for 13.8 percent and 14.2 percent, respectively, of the total deaths in these years. In 1998, the estimated adult prevalence rate for the entire country was 19.7 percent, with the figure reaching 28 percent in urban areas (MOH/CBOH, 1999). In addition to its effect on life expectancy, the AIDS epidemic is exacting a toll on all sectors of the economy, from the rising direct cost of illness associated with care of the sick, to the indirect cost to the economy in terms of lost production, to the increase in the dependency rate as the productive age group is hardest

hit. AIDS is also attributed to a rapidly growing orphan population. Of the 1.65 million children in 2000 estimated to have lost at least one parent, some 500,000 have lost both to AIDS (Seshamani et al., 1999: 58-59).

3.5 Health Sector Organization, Reform, and Financing

3.5.1 Sectoral Structure

At the time of independence, the distribution of health facilities in Zambia was highly uneven. Health services were provided primarily either by the mine facilities in the Copperbelt and along the line of rail, or through mission facilities in rural areas, although there were a few government hospitals located in provincial capitals and other principal towns (Freund 1986). The mine and mission sectors accounted for 50 percent of both doctors and beds in the country at that time (Nalumango 1972). Although the First National Development Plan allocated 69 percent of capital investment to the three provinces along the "line of rail,"[9] the 3 percent allocated to the health sector nationwide is considered to have enabled considerable expansion of the network of primary-level facilities throughout the country (Kalumba and Freund 1989). Table 3.6 shows the near doubling in the total number of primary-level facilities between 1972 and 1990. In addition to the increase in primary-level infrastructure, the nature of health service delivery also began to shift towards more preventative activities in the post-independence period, particularly through the establishment of under-five clinics (Nalumango 1972).

Table 3.6. Expansion of Primary-Level Facilities, 1972–1990

	1972	1980	1985	1990
Government	385	589	716	796
Mission	75	66	75	94
Mine	42	66	65	72
Total	502	721	856	942

Source: Ministry of Health (1992a); Nalumango (1972)

A university medical school and a number of nursing schools were also established following independence to alleviate the reliance on expatriate personnel.[10] Although the number of hospitals remained broadly stable, the number of beds more than doubled between 1964 and 1987 (Martin 1994). Missions continued to provide health facilities in rural areas under a grant-in-aid system in which the government provided a substantial portion of the operating costs. Mine hospitals and health centers continued providing services to the miners and their families. Zambia also has a thriving traditional sector, comprising traditional healers and traditional birth attendants. These operate mostly in rural areas where clients pay for services in cash or in-kind.

[9] These three provinces, Central, Copperbelt, and Lusaka, actually received 82 percent of the actual expenditure (Kalumba and Freund 1989).
[10] In 1972, it was estimated that of 527 practicing doctors in Zambia, only 19 were nationals (Nalumango 1972).

Table 3.7 summarizes available health facilities in Zambia, according to type, for the period 1990–1995. The table also shows the average percentage increment in the number of the facilities over the same period.

Table 3.7. Health Facilities in Zambia, 1990–1995

Facilities	1991	1992	1993	1994*	1995	% Increase 1990–1995
Hospitals	83	84	84	85	84	2.4
Health centers	1,021	1037	1106	1110	1082	14.9
Total	1,104	1121	1190	1195	1166	13.9
Leprosaria	15	15	15	15	15	0
Beds & Cots	17,128	17507	17077	16999	16960	0.2
Hospital Health Centers	7,931	8195	9322	9576	9502	24.2
Total	25,059	25702	26876	26575	26462	7.7

Source: CSO (1996)
Note: *1994 figures are provisional

In terms of administration, since the First Republic a central Ministry of Health has been responsible for formulating health policy, planning, issuing policy guidelines, and allocating funds. The highest administrative officers of the MOH were the permanent secretary and director of medical services. The director was in charge of administrative matters while the permanent secretary was the political head responsible for policy decisions. Provincial medical officers (PMO) in the nine provinces supervised district medical officers in each of the then 57 districts. Coordination committees at the provincial level brought together representatives from other groups and related departments (e.g., land, water, education, and agriculture). This structure remained basically unchanged until 1984 when the post of an assistant director of medical services with the responsibility of evaluating primary health care (PHC) at the national level was created.

Prior to 1989 the permanent secretary within the MOH had been the warrant holder for all MOH funds. This changed in 1990 through government-wide decentralization to the provincial level in response to general concerns that districts were not receiving proper allocations (Bennett 1993). At the time of the change of government in 1991, funding for the MOH was being channeled through two different mechanisms. The budget for MOH headquarters and various hospitals and other bodies came directly through the permanent secretary, MOH, while sectoral budgets for the provincial level and below were the responsibility of the provincial administration rather than parent sectoral ministries. The handling of funds at this level was the responsibility of the Provincial Accounting and Control Unit, known as PACU, situated within the provincial permanent secretary's office. Procedures relating to both recurrent and capital budgets at that time were as described below in the words of interviewees:

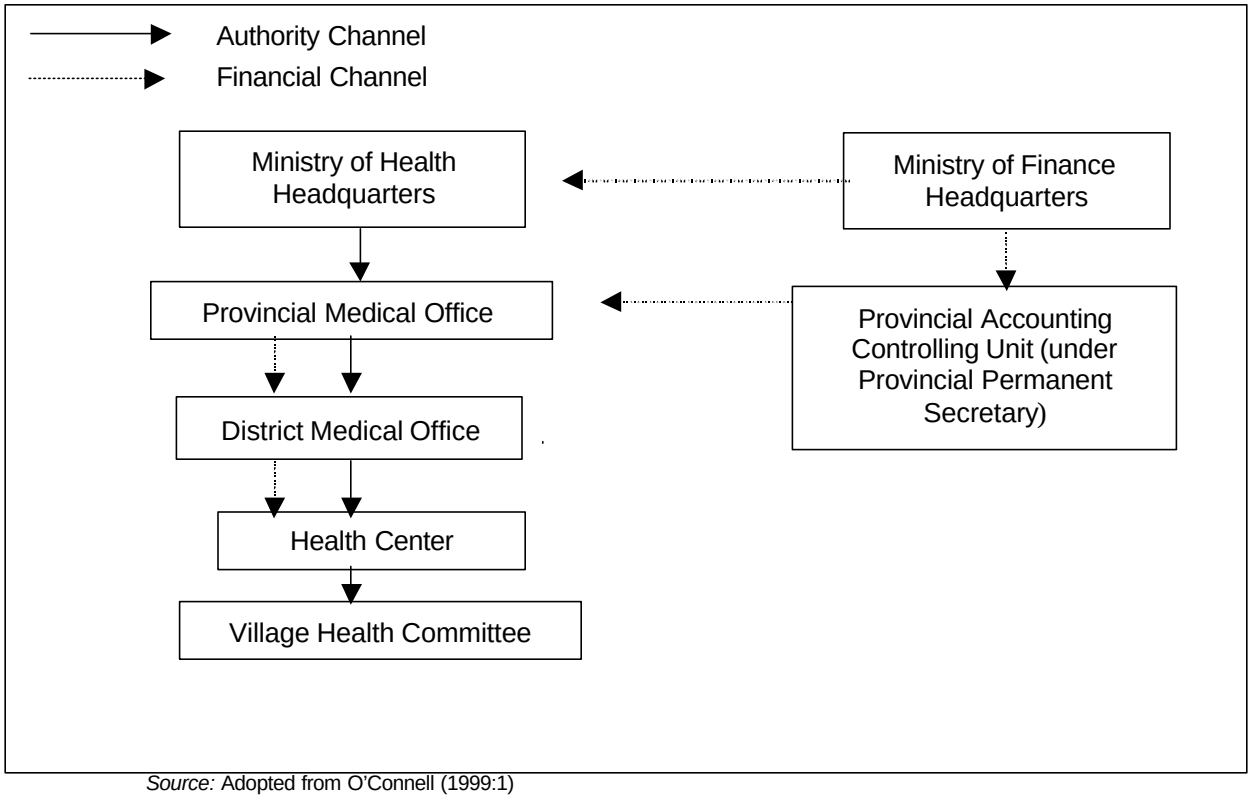
"...these big ministries had to get their money in provinces for districts through the PACU system… At the time Finance would just give a block allocation to provinces, basically a devolved budget not a deconcentrated budget. So how the province spent it on police, health, education, it was up to the province." (external technical advisor)

"For instance on capital, when it came to capital allocations, the provinces were given a certain amount of money and they were to plan. So within the provincial permanent secretary's office they

would decide to give allocations to various ministries or department, and they would give you a ceiling and you would operate all your activities that you want to plan for on capital within this ceiling." (former MOH official)

Figure 3.1 shows the structure of the MOH at the time of the election, indicating the channel of funding for provincial health services.

Figure 3.1. Organizational Structure of Ministry of Health at the Change of Government, 1991



Source: Adopted from O'Connell (1999:1)

3.5.2 Financing of the Zambian Health Sector

The primary source of financing for the Zambian health sector is government revenue, largely channeled through the MOH and some through the Defense Medical Services. It also receives funding through allocations to other ministries and departments, such as Community Development and Social Services (UNZA 1999). During the UNIP era, funding of social services generally was on the decline, as shown in Figure 3.2.

Figure 3.2. Social Sector Spending in Zambia as Percentage of Total Government Expenditure, 1980–1992

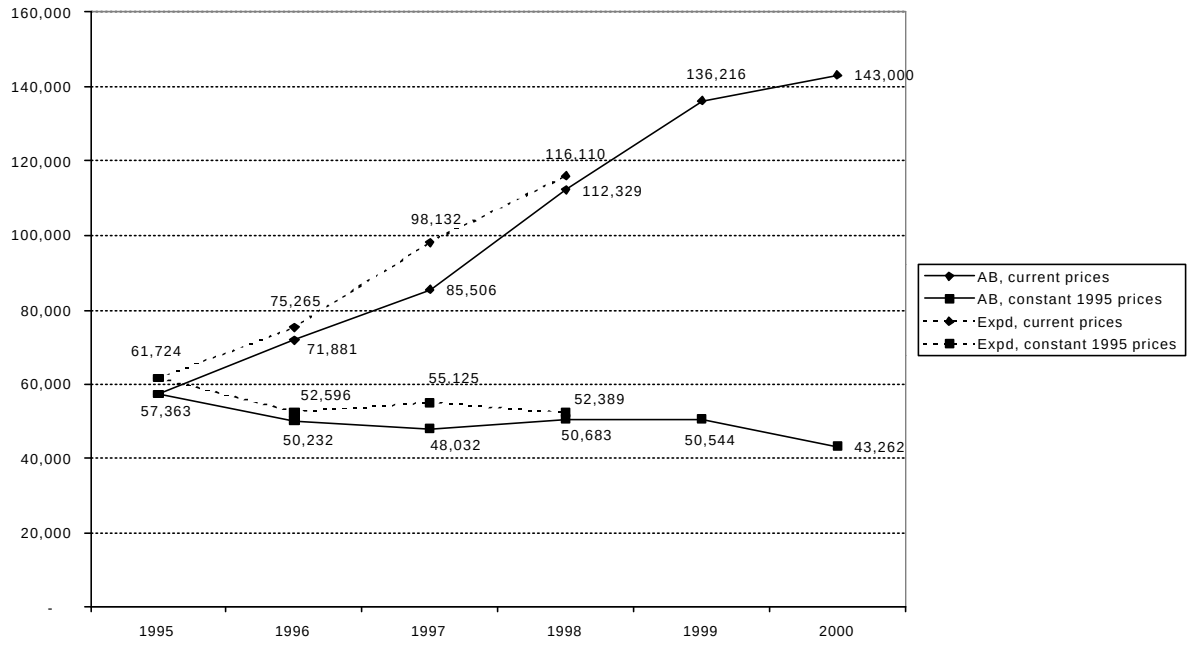
Source: Kamanga (1995)
Note: The straight line shows the trend over the period.

As a result, the MMD government inherited a health system that was seriously deteriorating. As MOH/UNICEF/WHO/World Bank (1996) argue, the health care system was near collapse by 1990. Government could neither maintain nor replace the deteriorating infrastructure. Most programs such as primary health care were performing poorly. Health centers and hospitals were left with chronic shortages of drugs and medical staff. New capital building projects virtually stopped while maintenance backlogs became more acute. The MMD government also found a desperate imbalance of medical facilities particularly between rural and urban areas. Officials interviewed in 1998 also confirm that

"regarding rural health development, there was an imbalance in resource allocation in favor of urban areas at the expense of rural areas" (interview data)

Despite some successes in raising the MOH share of the overall government budget from an average of 6.4 percent in the early 1980s (World Bank 1992) to an estimated 14 percent in 1998 (MOH 1998: 121), government funding for health care declined in real terms after 1991. Figure 3.3 shows that although there was a steady increase in the nominal value of both the final MOH budget and expenditure figures, in real terms, funding to date has not regained its 1995 level.

Figure 3.3. Trends in MOH Budget and Expenditure in millions K, 1995–2000[11]



Source: GRZ (various years), Yellow and Blue Books
Notes: AB = Authorized budget[12]

However, government funding is only one source of finance for the sector. Table 3.8 shows the overall breakdown by source as estimated in 1995.

Table 3.8. National Health Expenditure by Funding Source

	1995
GRZ	41
Donors	30
ZCCM	13
Other companies	2
Missions	2
Other NGOs	1
Households	11
	100%

Source: UNZA-IHE (1996: v)

[11] Expenditure figures exceed authorized budget figures due to extra budgetary disbursements (e.g., during a cholera outbreak), which are made to the ministry from other government budget lines, but are accounted for as MOH expenditures (personal communication, MOH official).
[12] The term "authorized budget" refers to the final figures, including supplementary allocations made during the course of the financial year, as opposed to the approved budget, which is what passed by Parliament in January at the start of the fiscal year.

Partly because of the financial crisis, reliance on external donor resources increased, beginning in the 1980s and continuing into the 1990s. In 1983, for example, donors contributed more than 29 percent of the total MOH expenditure (Kalumba and Freund,1989). In subsequent years, donor contributions to the total national health budget have increased while government budgetary allocations have steadily declined. Although accurate figures both on the amount and the proportion of donor expenditure in the sector have been difficult to determine, as with other sources of finance, Table 3.9 shows the trends in government and donor funding ratios from 1995 through 1998, according to one recent source.

Table 3.9. Government and Donor Spending in the Health Sector, 1995–1998

Year	Government %	Donor %
1995	66.7	33.3
1996	54.3	45.7
1997	49.0	51.0
1998	38.3	61.8

Source: Daura and Mulikelela (1998: 57).[13]

3.5.3 Restructuring and Reform: MMD Health Policy

Despite the acknowledged expansion of infrastructure during the UNIP era, the continued macroeconomic decline meant that the new government inherited a health service incapable of delivering basic services to the population. As was the case with other countries in the region, reduced social sector spending had resulted in dilapidated buildings and in shortages of drugs, transport and equipment, and funds for fuel and allowances. As a result, many health professionals left to seek work elsewhere, while those who remained suffered from low morale.

During the pre-1991election period, two parallel processes of broad health policy development were ongoing in the health sector. First, within the MOH, a group of senior officials, together with some representatives from the donor community, had increasingly come to accept that the health system in its current form was not meeting the needs of the Zambian population, as witnessed by the growing morbidity and mortality figures. In the words of one of the MOH officials involved, *"...resources were dwindling, but the needs were piling up..."* A process of internal institutional restructuring was therefore initiated within the MOH, through a *"spontaneous effort from the professionals...* (who were) *...tired of mediocrity"* (interview data). This encompassed thinking on decentralization and built on the earlier Medical Services Act of 1985, which had enabled the creation of management boards in the larger hospitals.

At the same time, following the formation of the MMD as opposition to the incumbent UNIP government, Dr. Katele Kalumba, a member of an informal policy advisory group, was charged with developing a health policy framework for MMD should the party win the elections. This was then debated among a small group, later to become the MMD Health Committee, which included Dr. Boniface Kawimbe and Professor Nkandu Luo, both subsequent ministers of health. However, Dr. Kalumba, who came from an academic background and had gained widespread regional and international experience through doctoral studies in Canada and as a consultant for UNICEF, WHO,

[13] Data taken from MOH/CBOH (1997) *Summary Annual Report for 1996*, and GRZ (1998*) Estimates of Revenue and Expenditure* (Yellow Book)

United States Agency for International Development (USAID), and others, is widely believed to have been the architect of the MMD position (interview data). The MMD health policy paper, *Managing for quality: a healthy people policy framework* (Kalumba 1991) provides the vision and core values upon which the subsequent reform program was to be built, focusing on local participation and the extension of democratic values to health service development and management. The paper emphasized the need for Zambians to commit themselves to building a health care system that guaranteed *"equity of access to cost-effective, quality health care as close to the family as possible,"* a vision carried forward into the final MOH policy document. The strategy to achieve this aimed at improving the health care system through the restructuring of the managerial system. This was to be executed according to the three key principles of leadership, accountability, and partnership (LAP).

With the coming to power of the MMD in 1991, both the MMD strategists and the MOH technicians who were working on possible reform options in parallel made concerted efforts to find solutions to the structural and organizational problems of the health system and those relating to the constrained resource base. In the words of one prominent politician directly faced with the problems of the MOH at that time:

> *"...it was really like being in a jungle; it was like somebody parachutes you into the middle of some tropical rainforest and you really don't know what to do. Did you begin by bringing in more drugs, improving the conditions of service, retraining the people? ... It was a jungle of problems."*

Reforming the health system was seen as providing a lasting solution to the many problems, all of which needed immediate attention. Kalumba's close personal links with individuals within the MOH resulted in a smooth merger of the draft policy document developed internally within the ministry and elements of MMD's policy framework (interview data). This was accomplished through a number of consultative meetings with health workers from different levels of the systems.

In the words of participants in the process, the main idea behind the development of the policy document in late 1991/early 1992 was to come up with a *"compass, something that would be guiding us all the time,"* or *"a formula ... of agreed upon, laid down procedures"* to which all health workers would be able to refer when tackling problems within their districts but which would be flexible enough to allow for the diverse nature of the country. The task of developing such a "formula" was seen as a continuous process since the challenges of the health sector were not static and therefore required dynamic solutions. The three principles of reform articulated by Kalumba were carried through into the emerging policy document and frequently summarized in the mnemonic LAP.[14] Various definitions of the principles exist, and the most frequently cited, either in documents or in interviews undertaken for this study, are presented in Table 3.10. These formed the basis of *National Health Policies and Strategies*, the official government health policy document.

[14] The issue of sustainability was added later.

Table 3.10. Statements on the Key LAP Principles

Leadership	♦ "The Ministry of Health shall…lead and manage the process [of sectoral development and implementation of the vision]" (MOH, 1992: p29) ♦ "Under the reform process, the central Ministry is undertaking the leadership role in the health sector by coordinating work with donors and national programs and by delegating program implementation, for which they have little capacity, through decentralization." (Kalumba 1997) ♦ "We wanted to move away from individual leadership…to teams, developing teams, district management teams..." (interview data, MOH official) ♦ " We realized that no matter how well you are trained, if you are alone, you cannot influence the team." (interview data, MOH official)
Accountability	♦ "The MOH shall... [p]romote a health system that encourages accountability for consumers, providers, and the Government working effectively together for improved health status." (MOH, 1992) ♦ "not just in pounds and pence, but more management issues, to sort out the systems which at that time were not working" (interview data, MOH official)
Partnership	♦ "The MOH shall …collaborate with consumers and health providers to determine how best to improve the system; encourage partnership among all those concerned with health and health care" (MOH, 1992) ♦ "The strategy was two ways: 1) autonomous boards, the common people to come and run boards…so we created boards which really legally are the trustees of the government…. 2) we said that for people to have a say, you should buy shares in the health sector, and these shares were in the form of cost-sharing." (Interview data, MHO Official) ♦ "We could go on to partnership with the cooperating partners, partnership with the NGOs, partnership intersectoral, which is very important if you realize the determinants of health..." (Interview data, MHO Official)

Since its approval by the Cabinet in 1992, the *National Health Policies and Strategies* (*NHPS)* document has provided the framework for developing institutional and financial reforms in Zambia. In this document, the government outlined its overall objectives in the field of health, including the expansion and rehabilitation of health services, "*especially in rural areas."* This would ensure better accessibility, improved quality, and improved provision of primary health care services. In early 1992, a companion document, the *Corporate Plan* (MOH, 1992b), was also developed, providing an implementation plan for the policies and strategies articulated in *NHPS.*

MOH then embarked upon a radical program of health reforms, which involved a wide array of health actions such as decentralization, management systems development, infrastructure rehabilitation, human resource development, essential drugs, the essential package, and resource allocation, among others. In practice these have proceeded at different speeds and with varied success. Table 3.11 summarizes the key components of actual reform design and implementation since 1992, indicating the type of change.[15] From this it can be clearly seen that, in many cases, institutional reform and systems development preceded the legislative or policy action that legitimized it, demonstrating the "learning by doing" principle adopted so often in the overall reform process in Zambia.

[15] This table does not claim to be exhaustive

Within this package of reforms, decentralization was seen as the overall strategy for restructuring the health sector: *"The main core of the health strategy shall be managing for quality through a District Health Management System. The district shall be the basic unit of management where bottom-up planning and implementation initiatives meet the thrust of national policies."* (MOH 1992: 28). The financing reforms of focus in this study have therefore taken place in the context of a system that has seen a progressive increase in authority devolved to this level.

Table 3.11. Key Components of Zambian Health Reforms Since 1992

Date	Type of Reform		
	Institutional	**Systems Development**	**Legislative/Policy**
1992	Establishment of autonomous Hospital Management Boards at general and central level hospitals on basis of Medical Services Act of 1985		Cabinet approved of NHPS
1993	Creation of District Health Boards from 1993, legitimized in 1995 through the National Health Services Act		
1994		Initial development and implementation of Financial and Administrative Management System (FAMS) at district level and below. *Work continuing on hospital level FAMS development.*	
1995	Creation of the District Basket and associated Steering Committee Definition of essential package of services for up to first level referral services (1995/96)		National Health Services Act establishes legal basis for District Health Boards
1996	Creation of Central Board of Health, which includes four regional offices to replace the former nine provincial structures Institution of regular program of twice yearly consultative meetings with partners (on hold since change of minister in 1998)		
1997	Issuing of an external management contract for the running of Medical Stores Limited		Initiation of process to develop Comprehensive Health Financing Policy
1998	Re-establishment of National Malaria Control Program	Development and implementation of Health Management Information System at district level	Cabinet approval of National Drug Policy Cabinet approval of National Laboratory Policy
1999	Scrapping of regional offices and re-establishment of provincial structures (on paper – not implemented at time of writing) Restructuring of Central Board of Health		Cabinet approval of Reproductive Health Policy

3.5.4 Organizational Reforms

The main strategy of the health reforms has been decentralization to the district level, through the creation of autonomous District Health Boards (DHB) comprised of representatives from both the political arena and civil society.[16] Although District Health Management Teams (DHMTs), composed only of health officials, had been in place prior to the change of government, these had largely existed in name only, with no effective devolution of either responsibilities or resources. The reform aimed to rectify this, although *NHPS* stated that the DHMT planning function was to be transferred to the DHB, with DHMTs retaining implementation and monitoring functions (MOH, 1992: 64).

Plans to devolve resources to the districts originally met with some opposition from the Ministry of Finance and others.

"There was an outcry, I remember that, 'look there is no capacity, there are no people who know how to keep books, keep accounts, they will just misuse the money, they will steal the money.' So my feeling was that if we are a nation of thieves, let us decentralize the stealing, let everybody steal a little bit." (former Minister of Health)

However, for the reformers newly in power, such devolution of funds was critical:

"...to decentralize the power and the decision-making, you have to decentralize resources. You cannot have a situation where the center is spending money on behalf of districts. That goes against the whole concept." (former Minister of Health)

"*we noted that previous attempts to decentralize the services to the districts and communities did not always include, or invariably did not include, the decentralization of resources from the capital, Lusaka, to the districts where the services were actually being provided. Whereas authority, responsibilities were being devolved to districts, resources always tended to be withheld at the center."* (former MOH official)

At the same time, general and central hospitals were also given increased autonomy through the establishment of management boards, as had happened with the University Teaching Hospital following the passing of the 1985 Medical Services Act. Although *NHPS* was relatively vague on plans for the reform of referral hospitals, the creation of the boards was intended to enhance the efficiency of the hospital sector and also to increase their financial independence from government through the levying of patient charges.

A further component of institutional reform has been the separation of the political and executive functions of the MOH, with the latter currently performed by the Central Board of Health (CBOH), a body originally established under the 1930 Public Health Act and recognized again in the 1995 National Health Services Act. The MOH remains responsible for policy formulation, strategic planning, and overall coordination, legislation, budgeting and resource mobilization, and external relations. At the same time, there has been a broad split between the MOH as purchaser of services and the autonomous boards as health service providers. The MOH contracts with the CBOH, while individual district and hospital boards sign annual service contracts with the CBOH in which they

[16] The precise form of these boards has varied through time. *NHPS* talks of "elected members of the relevant Local Government District" (MOH 1992: 45), while the National Health Services Act of 1995 has more members appointed by the minister (GRZ 1995).

undertake a range of specified services to a given population in return for monthly grants from government and donor funds (MOH 1998b).

While proceeding initially according to a philosophy of "learning by doing," these organizational reforms were institutionalized with the passing of the National Health Services Act in August 1995, which provided the legal framework for the boards. Moves to "de-link" staff from the civil service to become direct employees of the various boards began in 1997, although the process stalled in 1998 due to heavy opposition from trade unions and a change of minister.

Development and implementation of broader government policy on decentralization has tended to lag behind that within the health sector. However, legislation in progress through Parliamentary procedures in 1999 aimed to devolve power to local government. It remains to be seen how the new health service structures will conform to such policy proposals.

3.5.5 Other Reform Components

Several other key components of the health reform program are briefly outlined below.

The *essential* or *basic package* refers to an identified set of cost-effective interventions aimed at addressing the major causes of the disease burden in Zambia. The concept of a package of services to be guaranteed for all Zambians actually predates the reforms, with Kalumba proposing *"a core of mandatory health programs to secure basic minimum standards of health for all"* in his 1991 policy framework paper (Kalumba 1991). However, in the first two years of the new government, little was made of this element of the reform agenda beyond including it in *NHPS* and as one of the seven components of the *Corporate Plan* (MOH 1992a; MOH 1992b).

Once attention turned to strengthening health service delivery, two broad processes became evident in the development of the package, which at the time of writing covered the district and subdistrict level only. Both of these processes were to a large extent initiated, if not driven, by the World Bank. In late 1993 and 1994, a team of predominantly Zambian health officials from various levels of the system worked under the supervision of the Health Reform Implementation Team (HRIT)[17] team leader to develop a list of interventions based on experience and "best practice" to address the major disease problems within the country. In late 1994 and through 1995, following the publication of the *1993 World Development Report: Investing in Health* and *Better Health in Africa*, this work was temporarily abandoned in favor of a series of workshops involving health providers from the various levels. This was intended to develop a Zambian essential package using the same methodology described in the above-named publications, but also as a capacity-strengthening exercise for district and hospital planning (interview data; Cederlöf 1996; MOH 1998b).

While the resulting intervention list is specified in successive versions of the *National Health Strategic Plan*, resource constraints combined with a failure to address complementary issues such as the drug supply and human resource development mean that implementation is generally believed to have been limited (Sukwa and Chabot 1996; interview data).

In terms of drug policy, Zambia is quite unusual in that it lagged behind other countries in the subcontinent in specifying a list of essential drugs. This occurred despite explicit focus on the need for efficiency gains and the existence of a long-standing donor-supported Essential Drug Program

[17] See Section 4.3.1.2 for a description of the Health Reform Implementation Team.

providing kits to health centers and community health workers. Since 1995, the Swedish International Development Agency (SIDA) has taken primary responsibility for assisting the MOH in developing a national drug policy, although major problems remain with procurement and drug shortages.

Recognizing the failure of the earlier health system to adequately collect and use health information for effective planning and management has caused this to become an area of some emphasis during the period of reforms. In addition, the restructuring of the health system to focus on the district has necessitated the development of new administrative systems at all levels, as has the nationwide introduction of cost sharing. Two main strands of information systems development have taken place. The development of a Financial and Administrative Management System (FAMS) can be said to have begun with the trial project on budgeting (see Section 4.2.2), just prior to the change of government, and continued as part of the District Capacity Building (DCB) Program through 1993 and 1994. Since then, it has taken off as a major activity within the HRIT, and subsequently CBOH, in terms of systems development and refinement, capacity strengthening, and routine monitoring. The development of the current Health Management Information System (HMIS) began somewhat later (Sukwa and Chabot 1996), although it had its origins in the existing MOH system. Following piloting in one province, the HMIS has since been "rolled out" with districts reporting a core set of indicators of input, process, output, and outcome (MOH 1998b, Annex vi). In addition, the annually updated *National Health Strategic Plan* has an associated set of performance indicators (MOH 1998b: Annex iv).

3.6 Summary

In summary, a number of key contextual factors seem likely to have influenced the financing reforms of focus in Zambia, as categorized below.

The political context

- The change of the political system from a single to a multiparty system created an impetus for radical policy change in the health sector, but the lack of an effective political opposition precluded effective policy debate of health reforms.

- General MMD support for health reform was also interpreted as popular support from the society for change in the health sector, although the previous policy of free care may have limited initial support for new cost-sharing policies.

- Substantial donor support as a result of the smooth transition to multiparty democracy has ensured the availability of resources to assist reform development and implementation.

The economic context

- The economic decline that occurred from 1970 to the early 1990s, particularly due to the decline in copper production and revenue, has constrained domestic resource mobilization and thus resource availability for the health system. This has promoted consideration of alternative health care financing policies.

- The implementation of the New Economic Reform Program has provided an enabling environment for prioritizing the health sector and its policies as important to broader development.

The health system context

- The deterioration of the health system by 1990 provided a spur to, and justification of, radical health policy change.

- The emphasis on decentralization within the MMD's post-1991 health reform program ensured the creation and strengthening of lower level structures that would play a critical role in financing policy implementation and would, therefore, also shape the pattern of financing policy implementation.

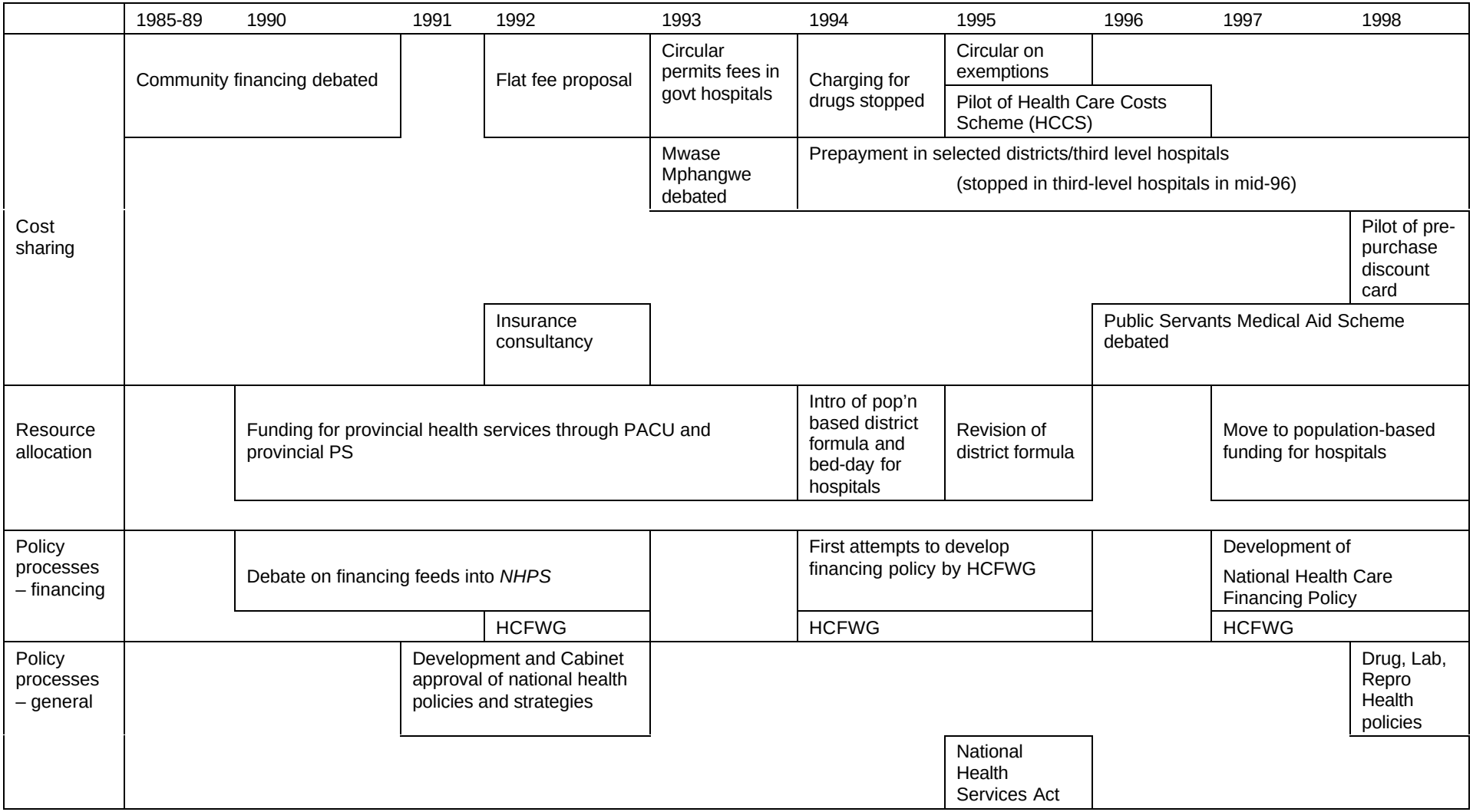
4. Evolution and Design of Health Financing Policy

4.1 Overview

The process of health financing reform in Zambia can be divided into three phases. Phase 1 started with the enactment of the Medical Services Act in 1985 and ended in 1991 with the articulation of the Movement for Multiparty Democracy manifesto. Following the landslide victory of the MMD on October 31, 1991, the reform program entered a second phase in which a number of studies were undertaken and more detailed ideas were developed and articulated in the Ministry of Health policy document. Phase 2 came to a close when the MMD government put into practice some of the ideas developed during this phase by embarking on an ambitious program to reform not only the health system but the entire civil service as well. Phase 3 can therefore be seen as the implementation phase, which began in 1993 and is ongoing. Figure 4.1 provides an overview of the development of the reforms of focus.

National Health Policies and Strategies and the *Corporate Plan* outlined a number of possible health financing options. Cost sharing through the introduction of user fees was identified as one means of supplementing the inadequate government resources (MOH 1992: iv, vi), while the need to develop mechanisms for improving the equitable distribution of resources was also stated (MOH 1992: iv). Following the approval of *NHPS*, more detailed policy development and implementation of these two reforms of focus have varied. Cost sharing was initially introduced in a largely ad hoc manner, through ministerial pronouncements and circulars, with relatively little consultation with or guidance for the actual implementors in health facilities. Nor was there any sensitization of the public who would now be expected to pay official charges for health care. Early moves to design and implement transparent and objective means of allocating government resources on the other hand took place within the context of a routine annual governmentwide budget process, but in addition they were seen as an integral part of the decentralization process. While cost sharing has remained high on the policy agenda since its initial (re)introduction in 1993, culminating in the dissemination of guidelines to different levels of the system in mid-1999 (CBOH 1999a), moves to strengthen and refine early mechanisms for resource allocation are only now receiving attention, despite having been discussed sporadically during the past five years.

Figure 4.1. Chronology of Health Financing Reform Development and Implementation in Zambia 1985-1998



4.2 Evolution of Financing Policy Debates Prior to the 1991 Election

Although the current reform period is generally considered to have begun with the development and cabinet approval of *NHPS*, moves were afoot during the late 1980s to consider alternative means of resource mobilization for the health sector in the face of macroeconomic stagnation. The need to develop official policy on cost sharing as part of a concerted attempt to improve the flow of resources to the sector was expressed in the New Economic Recovery Program for 1989-1993, which talked of the *"introduction of cost-recovery measures, particularly for nonlife-saving services"* (Ministry of Finance/National Commission for Development Planning (MOF/NCDP) 1989: 16). This was reiterated in the Fourth National Development Plan in 1989. As part of the emerging reform process within the MOH, a discussion paper advocating the need to change the policy of free care due to budgetary constraints, and outlining various cost-sharing options, was presented and discussed at a policy development workshop in Livingstone in 1989 (Musambo 1989).

The government's position on fees is unclear during the period 1985 to 1991, although this may be considered symptomatic of the general situation in the MOH at the time.[18] A detailed fee schedule, based on the 1985 Medical Services Act,[19] was drawn up in 1988 for implementation in hospitals. A statutory instrument was also issued in December 1990, but was withdrawn almost immediately on identification of an anomaly (Zambia Daily Mail, December 3, 1990). Following this incident, the then Minister of Health was relieved of her position. At this time, the government's position remained that fees should be levied on expatriates only and that Zambians should only pay for nonessential services like medical check-ups.[20]

Despite lack of clarity regarding official government policy at this time, two specific areas of early health financing reform activity are evident from the literature and interviews: first, fees were introduced within the mission health sector, and second, spontaneous community financing initiatives were introduced at the subdistrict level. These were taking place largely outside the ministry, but in parallel to an increase in thinking within the MOH about broader sectoral reform. Prior to 1991 there were also some moves to initiate budgetary reform.

4.2.1 Cost Sharing at Mission Facilities and through Community Financing Initiatives

Soon after independence, the government abolished fee paying at all health facilities, including those run by missions, as part of its broad policy of expanding access to basic social services. The financial gap in the mission sector created by the abolition of fees was filled by government support through a grant-in-aid towards the missions' running costs (Freund 1986). By the mid-1980s, the government was no longer able to sustain funding to social services, and the missions began to suffer in the same way as government facilities.

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[18] In the words of one of the incoming policy makers, *"Our perception of the way the Ministry ran [prior to the 1991 elections] was really what you might call in an ad hoc fashion. You used to get a lot of circulars…the whole system was run on directives as problems arose"* (interview data).

[19] The 1985 Medical Services Act had a broader remit than merely permitting fee paying as it also established the concept of Hospital Management Boards as a means of improving institutional management (Kalumba 1997). The fee schedule alluded to within the act was primarily intended for hospitals.

[20] However, it is of note that fees were introduced in Western Province in 1989. The province was at that time host to a Primary Health Care project financed by the Netherlands government, involving substantial technical assistance at district and province level. It may therefore have received some freedom in policy implementation.

In 1988, the Churches Medical Association of Zambia (CMAZ) took the initiative to find an alternative source of financing. Using the 1985 Medical Services Act as a legal basis on which to ask the community to make financial contributions to the mission health facilities, CMAZ introduced fees at the point of service (interview data). Minimal fee schedules were developed and implemented at mission facilities after efforts to sensitize the community and mobilize their support were conducted (interview data). However, during the first year of implementation, CMAZ realized only 10 percent of recurrent expenditure, which soon began to decline as the general economy continued on the downward trend. Because CMAZ was concerned about and sensitive to the socioeconomic circumstances of users, it felt it could not adjust the fee schedules upwards. As a result, the benefits of the user fee policy in terms of providing a substantial additional source of revenue were limited. What was gained, however, was the knowledge that fees could be both instituted and supported by the community.

The second broad stream of work on cost sharing during this period was documented in work undertaken by the Planning Unit of the MOH and supported by UNICEF during 1989-1990. This showed that community financing initiatives were in place in a number of localities around the country and had the potential to provide an alternative tool for mobilizing finances from the community. While not necessarily raising substantial amounts, one particular advantage of such schemes was that the revenues were retained at the point of collection and used to supplement the meager government revenues filtering through to that level in order to improve service quality (Bennett and Musambo 1990).

Although such community financing schemes were generally taking place outside the government realm, the evaluation findings provided input material into the further development of a cost-sharing policy. Such linkages happened particularly through Kalumba, who was part of a small group of MOH officials, donors, and other interested parties that met to discuss the findings of the community financing study and other related work (interview data). This resulted in a wide range of cost-sharing options being included in the MMD policy framework paper, together with a proposal to develop a study group to further research financing options (Kalumba 1991).

4.2.2 Piloting of District Budgeting

Before 1991 there were concerns about the efficiency of existing resource use, with a general feeling that the health system was not performing as well as it might to meet the needs of the population (interview data; MOF/NCDP 1989). A Swedish International Development Agency - supported review of planning and budgeting in the MOH took place in 1990**,** with the findings indicating that procedures within the ministry were unclear**.** The failure to link planned budget allocations to health sector objectives at the national level resulted in the health sector being likened to *"a black box"* (Lagerstedt 1991). Money was released to the MOH from the Ministry of Finance, but at the end of the year it was not always clear how this had contributed to stated health objectives.

Within the provinces, there was some concern regarding the system of global provincial budgeting. As Provincial Medical Officers were competing with other sectors for limited funds, *"(t)he department which shouts loudest is likely to receive most"* (Bennett 1993: 4). In addition, the incremental budgets prepared by Provincial Accounting and Control Units were often cut, apparently arbitrarily, by the Budget Office within the Ministry of Finance and Economic Development (MOFED), thereby again resulting in a situation whereby *"allocations bear little or no relationship to planned activities"* (Noormahomed 1994). In terms of the actual releases from PACU to the operational level, the frustrations were great, with a feeling that funds had been removed one stage

further from where they were needed than had been the case before (when funding came through PMOs):

> *"Initially the Provincial Medical Office used to make decisions but later on, through an act of reform, of decentralization to the province, creation of Provincial Accounting Units, it became even further away from the Provincial Medical Officer and so the story changed; it was always PACU has no money."* (interview data, former District Medical Officer)

At this time decentralization to the district level was rising on both the international and domestic health policy agenda. The ministry decided in 1990 to work with three districts to explore the possibility of bypassing the province and directly funding districts to remove one of the perceived bottlenecks to performance. This built on the MOH/UNICEF work on community financing and the strengthening of district functioning (Bennett and Musambo 1990, interview data), together with SIDA technical support to strengthen planning and management at central and lower levels. Although the initial release of funds to the pilot districts took place beginning in early 1992, the modalities of the pilot were worked out in 1991 by a small group comprising MOH, MOFED, SIDA, and UNICEF officials as part of the budget preparations.

4.3 Key Actors and the Policy Community, 1991–1999

A range of actors has been involved in both the design and implementation of health reforms in Zambia since 1991. The broad positions of those most heavily involved in the reforms of focus are summarized in Table 4.1, while a more general outline of individual players is given in the following subsections, distinguishing between the main categories in the table.

Table 4.1. Positions of Key Actors in Reforms of Focus

Actors	Resource Allocation	Cost Sharing
Government sector – central level	MOFED – supportive of use of criteria for geographical resource allocation, and of MOH withdrawal from PACU system MOH – strongly supportive of decentralized budgets and objective criteria for allocation	MOFED – supportive of retention of cost-sharing revenues within the MOH (1992 onwards)
Government sector – implementors	Districts – generally supportive of move to transparency, although some districts felt that formula didn't adequately reflect their needs	Referral hospitals – directors favored fees but opposed (privately) to 1994 prepayment
Political sector	Kawimbe – strongly supportive of move to per-capita basis	Kawimbe – strongly supportive of fees; proponent of prepayment in-kind Sata – felt fees too high. Strongly supportive of cash prepayment Kalumba – strongly supportive of concept of cost sharing generally
Donors	General support for principle of reallocating toward primary health care	UNICEF – concern in early years of implementation re financial barriers to access for priority services such as ANC, immunization
Zambian analysts	Little evidence of any interest	Participatory Assessment Group – early work suggested negative impact on financial access; more recent work less conclusive Dept of Economics – 1996 and 1998 work highlighted need for communication and consistency in cost-sharing policy implementation
Expatriate TA – long and short term	SIDA short term – proposal in 1993 for use of more rational basis for allocations SIDA long-term – strong proponent of budgetary reform DFID – concern over basis for hospital allocations WHO short term – proposed reallocation through growth	Short-term WHO consultants – early proponents (1991-1992) of formal health insurance, but more supportive of informal prepayment/insurance since 1996 Short term USAID (through Partnerships for Health Reform) – concern with strengthening cost sharing at operational level (1997-1998)
Social sector	CMAZ – individual churches against move to population-based funding for hospitals (1997)	CMAZ – supportive initially though concerned later about affordability Catholic Secretariat – opposed in context of widespread poverty

Source: document review, interview data

4.3.1 Key Ministry of Health Actors

4.3.1.1 Ministers

As stated in Section 3.5.3, the first Minister and Deputy Minister of Health following the change of government had been core members of the MMD Health Committee in the run-up to the elections. Dr. Boniface Kawimbe, an endocrinologist formerly based at the University Teaching Hospital (UTH), and Dr. Katele Kalumba, an academic holding joint positions with the Department of Community Medicine and the Institute of African Studies at the University of Zambia, were thus well placed to lead the reform process in its early stages. At the same time, their respective backgrounds led them to emphasize different elements of the overall reform.

Kawimbe is largely seen as championing the cause of the hospitals, quickly replacing UTH management,[21] creating additional hospital boards, and personally handing over checks for their running costs in a attempt to demonstrate their new-found autonomy under the MMD government (interview data, former MOH officials). Kalumba's contribution, on the other hand, was based on his broad health systems experience and is seen particularly in relation to the participatory nature of the proposed boards and the focus on the district and sub-district levels.

In January 1994, Kawimbe was replaced by Mr. Michael Sata. Sata came from Local Government and Housing,[22] and the MOH was his third posting during the MMD government. Although he had no background in health, Sata is widely seen as an experienced politician and had earned the nickname "King Cobra" in the opposition press.

In May 1996, Kalumba was promoted to minister when Sata left the MOH to concentrate more fully on his position as National Party Secretary and take up his new post as minister without portfolio in the Vice President's Office. Following her election to Parliament that year, Professor Nkandu Luo was subsequently appointed deputy minister. A consultant immunologist, she came from UTH where she had headed the laboratory services. She also had a long-standing involvement in issues of HIV/AIDS, heading the Society of Women Against AIDS in Zambia and as a patron of Tasintha, an nongovernmental organization (NGO) charged with providing alternative income-generating activities for commercial sex workers. Like Kawimbe and Kalumba, she had also been a member of the MMD Health Committee prior to and following the 1991 elections.

In March 1998, Kalumba was transferred to the Ministry of Tourism, and Luo promoted in his place. This was widely seen as a demotion for Kalumba, and may have helped to shape events in the MOH since then, as reform progress was widely believed to have been stalled following Luo's appointment. However, Kalumba's subsequent promotions first to Minister of Home Affairs, and more recently to Minister of Finance, suggest that he had not fallen permanently from grace within MMD.

4.3.1.2 Key MOH officials

The Planning Unit has played a key role in policy design during the period prior to and following the change of government. Key players during this period have been the successive chief health planners, both of whom started their health careers as health professionals, rising through the system

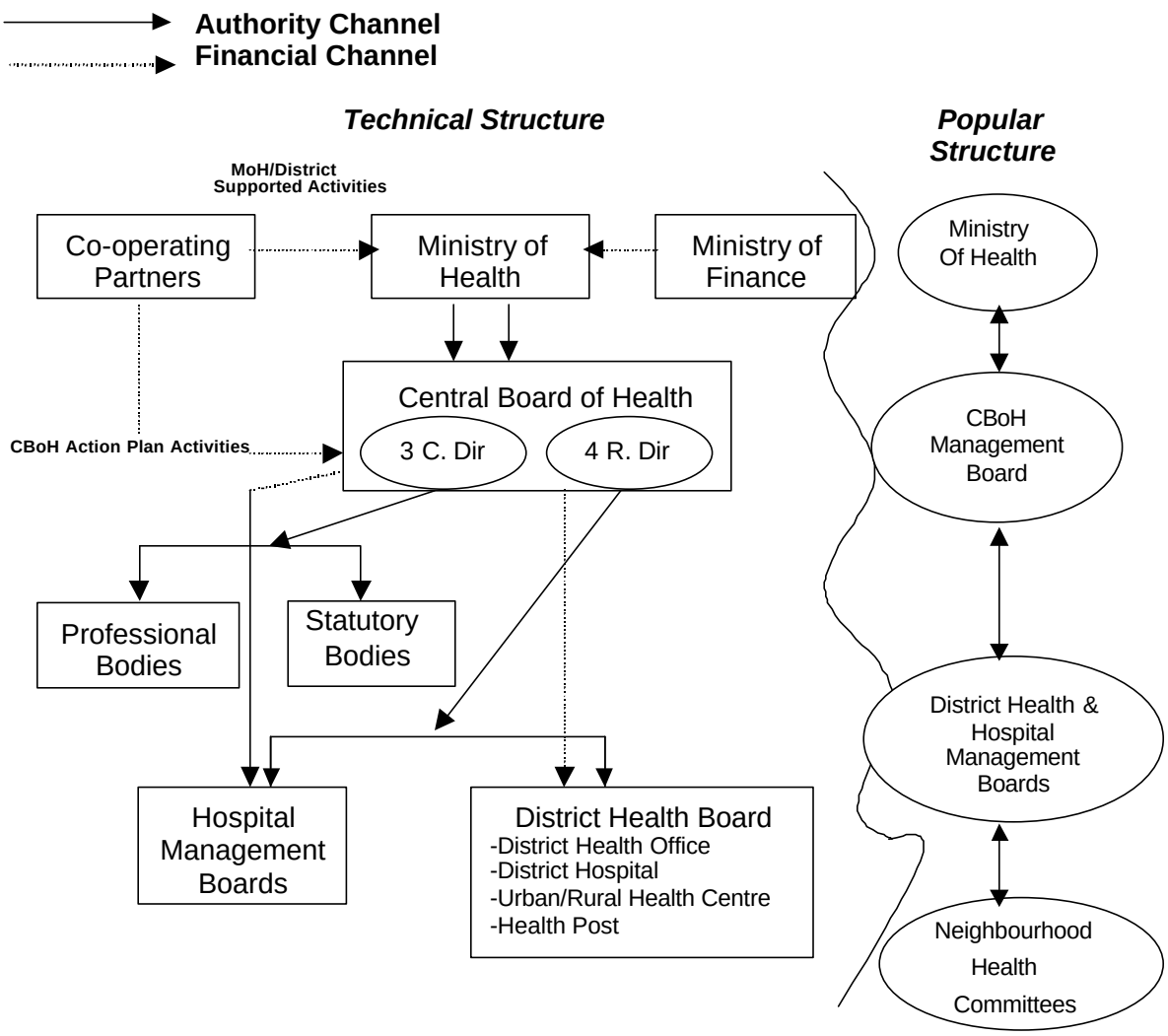
[21] This was later deemed by the courts to have been in error.
[22] Where he had worked with the then MOH permanent secretary.

to district and provincial positions prior to undertaking training overseas in health planning and management. In addition, the Planning Unit has been strengthened by the addition of two trained health economists since the change of government, together with the creation of a formal position of donor coordinator to handle the large and growing workload of day-to-day dealings with partners. However, the decision in 1996 to place the two health economists in positions not requiring their specific skills (both in general project management, with one doubling as the new donor coordinator) has meant that effective health economics capacity in the unit, and thus MOH as a whole, has remained limited. The Planning Unit has generally remained small in terms of human resources, particularly compared with its central role in the reform process, and has at times been overwhelmed by the tasks required of it. It has been strengthened during the past decade, however, by the presence of expatriate advisors. As part of the restructuring of the MOH headquarters, undertaken as part of the broader reform process, the status of the Planning Unit has been upgraded to that of a directorate, and the human resource position is being addressed.

One of the first actions taken following cabinet approval of *NHPS* was the establishment of the Health Reform Implementation Team to oversee reform implementation. The structure of the HRIT was largely geared towards supporting the new Danish International Development Agency (DANIDA) Health Sector Support Program, and it was initially very small with just three sections: District Capacity Building, Quality Assurance, and Administration. The former Deputy Director of Decentralization in the MOH headed HRIT, and over time it developed to include units or people responsible for such areas as Provincial Capacity Building, Health Management Information Systems, Financial and Administrative Management Systems, gender, and health systems research. Located in a separate building from other parts of the ministry, day-to-day running costs were included in the Danish program, and technical advisors were based within the HRIT.

This body was always seen as an interim structure, designed to overcome some of the bureaucracy associated with government in order to facilitate speedy progress with reform implementation. In late 1996, the CBOH, with three directorates as shown in Figure 4.2, replaced HRIT. However, the intended staff establishment was never fully recruited, there have been extended periods of absence by one or more directors, and its autonomy has been limited. This has laid CBOH open to criticisms from the MOH that it has failed to achieve its objectives, and since the appointment of Professor Luo as Minister of Health, its future has been uncertain. During 1999, proposals for restructuring of the CBOH were submitted to the Cabinet Office for approval

Figure 4.2. New Health Structures as of Late 1996



Source: O'Connell, (1999)

4.3.2 Zambian Analysts

The role of Zambian analysts in health financing reform was initially quite limited, with the exception of Kalumba's involvement in early meetings prior to the change of government. Growing interest in Zambia's experience, however, from academic institutions outside the country, such as the London School of Hygiene and Tropical Medicine and the Karolinska Institute in Sweden, has led to collaborative research being undertaken in various departments of the University of Zambia, known as UNZA. Notably such research has involved the Department of Economics, the Rural Development Studies Bureau (RDSB), and the Institute of Economics and Social Research (formerly known as the

Institute of African Studies).[23] Around 1994 to 1995 SIDA changed the nature of its technical assistance in some subsectors from long-term in-country advisors towards tri-partite institutional collaboration between the MOH, UNZA, and Swedish institutions such as the Institute for Health Economics in Lund.[24] USAID has established a similar arrangement under its Partnership for Health Reform project, linking government, university, and overseas private sector institutions.[25]

Most involvement by Zambian analysts has therefore been through internationally supported collaborative research and evaluation, although one notable exception at various points during the period under study was the Health Care Financing Working Group (HCFWG) discussed in Section 4.3.5. In addition, staff of the RDSB later set up the Participatory Assessment Group (PAG) as an independent body undertaking commissioned participatory research work for agencies such as the World Bank and Department for International Development, UK (DFID). HRIT and CBOH have used PAG to undertake a number of beneficiary assessments of different aspects of the reforms, either separately or as part of broader reviews (e.g., Sumaili and Milimo 1996). A further exception is the involvement of a private Zambian consultancy company, the Centre for Health Science and Social Research (known as CHESSORE), in an initial baseline evaluation of reform impact at district level, which has been followed up by more recent studies along similar lines.[26]

4.3.3 Donors

As mentioned in Section 3.5.2, the Zambian health sector has benefited from substantial external assistance over the years, with a significant increase in the inflows since the change of government and articulation of the reform program. In terms of the multilateral agencies, WHO and UNICEF have been involved in the sector since before the reforms and appear to have played a significant role in furthering discussion of decentralization and cost sharing through community contributions (interview data). The World Bank, having suspended its involvement with Zambia's break from the international financial institutions in the late 1980s, began discussing renewed sectoral support in 1992. Since then the Bank has been a major player, initially as a facilitator of early discussions on reform implementation, and more recently as a co-financier through its sectoral loan.

Most of the major bilaterals are involved in the health sector, with the main players in terms of finance and influence being SIDA, DANIDA, Netherlands Government Directorate General for International Cooperation (DGIS),[27] USAID, and DFID. DANIDA has been a strong supporter of the decentralization process, supporting the establishment of the HRIT, district planning and management capacity strengthening, and the development of appropriate financial systems. SIDA has focused more on national level planning and management capacity, and more recently on strengthening health economics capacity within Zambia through support to UNZA. In relation to health financing, these organizations' main concern has been the development of an overall policy to provide the rationale for different individual mechanisms. The Netherlands government has supported service delivery and management strengthening by placing Dutch doctors in all district hospitals and District Health Management Teams in Western Province, and more recently by providing technical assistance at the provincial level. USAID has shifted the nature of its support from relatively small-scale involvement in family planning and AIDS at the start of the reform period, to a large program of support for basic

[23] e.g., Booth et al. (1995), Atkinson et al. (1996), Kalyalya et al. (1998), Gilson et al. (1999), and Kamwanga et al. (1999).
[24] e.g., UNZA-IHE (1995), UNZA-IHE (1997).
[25] e.g., Diop et al. (1998), Daura et al. (1998)
[26] see Ngulube and Mwanza (1996)
[27] Netherlands Government Directorate General for International Cooperation

health service delivery and health financing. DFID has also shifted over the period from project-type support to such discrete areas as urban health in Lusaka and contraceptive procurement and distribution, to a position of broader sectoral support.

4.3.4 Technical Advisors

Like many low-income countries,[28] the Zambian health sector has received substantial technical assistance from multilateral and bilateral partners in different areas of the reforms. This has taken the form of long-term advisors, i.e., those who have stayed in Zambia for one or more years, and short-term consultants. Generally, these consultants have provided input from an external base, although sometimes they have conducted a series of visits, thereby providing some continuity.

In the area of health planning and financing, the majority of advisors have been provided through multilateral agencies such as WHO and UNICEF, in recognition of the ministry's preference for such "sensitive" policy areas to remain independent of bilateral agency views. Among the long-term advisors, defined as those who lived in country for over a year, the exception to this was the involvement of a SIDA expatriate health planner/economist from 1990-1994.[29] The SIDA expatriate and three of the four UNICEF/WHO health economists and planners who provided support to the reforms between 1993 and 1999 were based directly within the Planning Unit,[30] and all were involved in various aspects of the decentralization and financing reform processes. Another WHO advisor was engaged in more general policy development. DANIDA provided considerable technical assistance to the decentralization process, with long-term advisors working on quality assurance, financial management systems, and hospital reform. Since early 1999, USAID has had a health financing specialist as part of the Partnerships for Health Reform (PHR) team supporting policy strengthening.

The majority of short-term consultants working on health financing have also been linked to WHO or UNICEF, from the early work on individual financing mechanisms in 1992 undertaken prior to the finalization of *NHPS*, to more recent visits in 1996 and 1997 aimed at revitalizing the process of development of an overall health financing policy (see Section 4.4). More recently, however, USAID, through PHR, has been a significant player.

The majority of the evaluations of cost-sharing reforms that have been undertaken in Zambia since the policy was first implemented have seen the involvement of either long-term or short-term technical advisors. Table 4.2 lists the various evaluations.

[28] In contrast to South Africa, the other country studied under this project.
[29] The change in focus from long-term senior expatriate advisors to the funding of more junior staff through WHO, together with periodic support from Swedish institutions, was a reflection of SIDA's changed approach to technical assistance in the early 1990s. This has been reversed to some extent since the creation of the CBOH, which was modeled after the Swedish example of a central level executive agency.
[30] The fourth was based at UNICEF but given considerable leeway to work directly with both the Planning Unit and the HRIT.

Table 4.2. Studies of Cost Sharing, 1989-1999

Authors/ Advisors	Report Title/Subject	Cost-Sharing Option Covered	Funded by
Bennett and Musambo, 1990	"Community financing and district management strengthening in Zambia"	Community financing	UNICEF
Forsberg 1990	"Household health expenditure survey: Western Province, Zambia"	User charges in Western Province	WHO
Arhin 1992	"Health financing in Zambia: An approach to cost sharing"	Feasibility of and possible modalities for cost sharing	UNICEF Lusaka
Ron 1992	Consultancy report on options for introducing formal health insurance	Feasibility of National Health Insurance	WHO
Souters 1993	Consultancy report on extension of the Mwase Mphangwe Initiative	Feasibility of prepayment in-kind	WHO
Kahenya and Lake,1994	"User fees and their impact on utilization of key health services"	Evaluation of user fees in Lusaka	UNICEF Lusaka
Booth et al., 1995	"Coping with cost recovery"	Evaluation of impact of user fees in selected districts	SIDA
Kalyalya and Milimo, 1996	"User fees in the health sector: Policy, practice, and perceptions"	Evaluation of the impact of user fees in selected districts	World Bank (Zambia) Study Fund
Kalyalya et al., 1998	"Promoting equity within cost-sharing schemes: Report of the Zambia case study"	User fees and prepayment in selected districts	UNICEF New York
Daura et al., 1998	"District cost sharing"	Evaluation of user fees and prepayment	USAID (through PHR)

4.3.5 Other Bodies

Arguably the only formal process for overseeing the development and implementation of health financing policy reform was through the HCFWG, the evolution of which is presented in Figure 4.3. This grew out of the informal gatherings of MOH officials, Zambian academics (including Kalumba), and technical advisors/donors who met to review the early work undertaken by the Planning Unit, UNICEF, and SIDA in the late 1980s (see sections 4.2.1 and 4.2.2). Initially proposed in the MMD policy framework paper as a study group, and formally referred to in *NHPS* as *"a Working Group on health sector financing"* (MOH, 1992), HCFWG met on a largely *ad hoc* basis during 1992, primarily as a forum for the debriefing of visiting consultants. The group brought together a range of stakeholders from the government, NGO, and private sector.

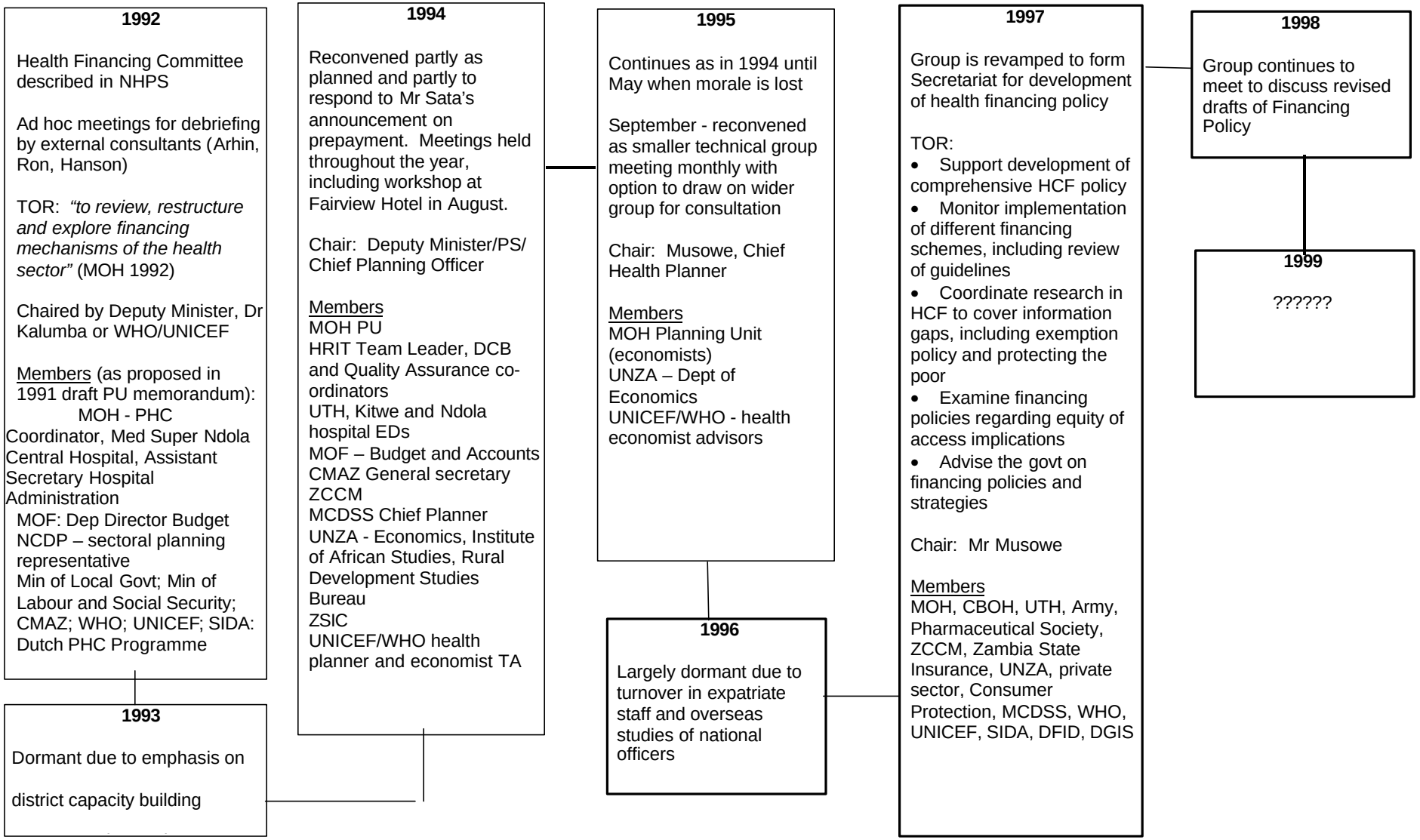
During 1993, HCFWG was dormant due to the emphasis given to the District Capacity Building process and the resulting absorption of the relatively limited number of central level officials to work in that process. HCFWG was reestablished in 1994 following the appointment of Michael Sata as Minister of Health and his pronouncements about the introduction of prepayment (see Section 4.6.2). During 1994, HCFWG met regularly to discuss policy options around prepayment and exemptions

and to undertake early work to develop a comprehensive financing policy. However, attendance waned as members became frustrated that their efforts were not recognized by the minister. Towards the end of 1995 it was revamped as a smaller, more technical group, although this appears to have lasted only as long as the expatriate economists were in country. A changeover in personnel meant that the HCFWG was again dormant until the process of comprehensive health financing policy restarted in earnest in early 1997 under Kalumba, when it took on the role of coordinating inputs to the policy document. More recently the group has again been dormant as the process stalled with the change of political leadership in the ministry in early 1998.

The Budget Steering Committee is a ministry body that has also existed episodically during the period under study (interview data). There have been persistent calls for its formalization as a forum for overseeing the annual preparation of the budget together with the monitoring of releases and expenditures, but little evidence was found of its functioning during the study period. The exception to this was a brief period in late 1993 during preparation of the first MOH budget to include district grants.

A final body is the CMAZ. CMAZ is the umbrella organization acting on behalf of church health institutions around the country. Given the substantial size of the mission health sector, it has always been viewed as a partner in health service delivery and included in many policy development forums (e.g., budget preparation workshops, consultative meetings, and HCFWG). However, relations between CMAZ and its constituent churches and various personalities within the MOH have varied over time, particularly in relation to the changed nature of district funding and the position of church institutions within a decentralized system.

Figure 4.3. Evolution of the Health Care Financing Working Group, 1992-1999



4.4 Development of an Overall Health Financing Policy Framework

Before describing the reforms of focus, it is worth outlining the more general health financing policy context in which such reforms were being developed. While *NHPS* and the Corporate Plan are clear on the nature and purpose of decentralization, the picture has been less clear regarding financing reforms generally, as noted by observers in 1996: *"The handling of health financing by the MOH in Zambia contrasts sharply with the clarity and sureness of touch which has characterised many other aspects of the reform programme."* (Cassels and Janovsky 1996).

The broad policy statement both from Kalumba (1991) and in *NHPS* is that *"everyone in Zambia with an income shall contribute to the maintenance of his/her health"* (MOH 1992a), and this has remained constant throughout the period under study. However, the motivation behind this statement has varied, and this may have hampered the articulation of an overall financing policy within which individual mechanisms could be developed in an efficient and complementary manner.

One difficulty in the Zambian context is to know what actually constitutes health financing policy. Obviously what is included in *NHPS* may be considered official policy, but, at least in terms of cost-sharing reforms, actual implementation has been very different, as shown in Section 4.6. Beyond the few circulars or policy statements that did reach implementors, much health financing policy development has been undertaken in Lusaka and has not progressed beyond draft document stage. In the words of one long-term advisor, who articulated a commonly held view, *"staff at the center might well describe the financing policies in a particular manner, as would documents disseminated to donors and central staff. However, these policies had often not been communicated to the implementors, or not effectively communicated."* Table 4.3 lists some of the different documents and processes that might be considered part of the development of "official" health financing policy.

Table 4.3. Overall Health Financing Policy

Date	Document	Process
1992	*NHPS* Corporate Plan	As outlined in Section 3.
1993	MOH circular on fees (MOH 1993a) MOH (paying for quality health care) MOH circular on use of fee revenues	Believed to be decision by Minister and Planning Unit (interview data) Developed by Planning Unit – not discussed with other technocrats/advisors Believed to be ministerial decision (interview data)
1994	HCFWG (1994) draft financing policy	Developed by HCFWG following August 1994 meeting at Fairview Hotel (see below)
1995	Draft health financing policy (MOH 1995) Circular no. 4 of 1995: Exemption from paying user fees and prepayment fees (MOH 1995)	Planning Unit – not discussed with HCFWG Issued following HCFWG discussion re exemptions, and press and donor concerns regarding reduced access for preventive services
1997/98	Draft health financing policy (successive drafts)	Consultative process initiated following visit by WHO consultant (Aug. 1996) and supported by SIDA. Halted with appointment of Luo to minister; as draft policy, "got stuck" within her offices awaiting approval

Note: The second circular on cost sharing issued in 1993 specified that 10 percent of revenues should be used for staff bonuses. Unfortunately, researchers were not able to find a copy of this circular. It is referred to in Choongo and Milimo (1995), Kalyalya et al. (1998), and by interviewees.

That there has always been a role for different sources of finance is not disputed. In the words of one of the early MMD policy makers, *"...we established the following: 1) government would continue to be the major contributor to health financing in Zambia; 2) fortunately for us, you know our cooperating partners, the external donors, will probably continue to have a role in financing health; 3) we said out of pure necessity, because of changed circumstances on the ground, every able-bodied Zambian earning an income must make a contribution towards health care"* (interview data). However, the difficulty comes in determining what services were to be guaranteed through the combination of these resources, ensuring equity and efficiency through complementary design of individual financing mechanisms, determining the mode of allocation, and resolving how access was to be guaranteed to those unable to contribute.

4.5 Planning, Budgeting, and Resource Allocation Reforms in Support of Decentralization

Activities related to planning, budgeting, and resource allocation are by their nature intertwined. Since implementation of the reform program began, action in this area has been taken in such a way as to support the decentralization reforms. Table 4.4 outlines the annual health sector planning and budgeting process, how it relates to the overall government fiscal timetable, and how it has changed over time. Subsequent sections give more details on aspects of these changes.

Table 4.4. GRZ/MOH Planning and Budgeting Process, Post-1991

	GRZ/MOFED	MOH/CBOH
July		MOH begins preparing draft budget estimates for health sector Districts given initial ceiling/guideline through HRIT in written circular (1994/1995), and through CBOH Planning Guidelines at interdistrict meeting (1997-99)
August	MOFED drafts budget ceilings for each sector	
October	MOFED PS chairs budget workshop to revise budget requests and provides final budget ceilings for each sector. Each ministry produces a revised budget. Workshop attended by PS, Planning Unit, and accounts from each ministry	
November		1994/1995 District plans and budgets reviewed by HRIT/MOH and comments submitted back. Plans for provinces and central level to be based on observations from district plans. 1997-99 Districts review their proposed budgets with regions/ CBOH/MOH at the second interdistrict meeting
December	Each ministry defends its final budget to MOFED and, using the final budget approved by MOFED, each begins to prepare a Parliamentary Brief	1994/1995 Districts review their proposed plans/budgets at the Annual General Meeting in Lusaka
January	MOFED presents the GRZ budget to Parliament	
January-February	Each minister presents final budget to Parliament and, once approved, the budgets are "Approved Provisions," published in the "Yellow Book"	

Source: adapted from Abt Associates (1998) using additional information from CBOH (1998) and interview data (MOH, CBOH officials)

4.5.1 District Capacity Building: Developing District Plans and Budgets

While the trial project with decentralized budgeting was still ongoing in the three districts (see 4.2.2), it was agreed within the MOH that the strengthening of district management and service delivery capacity should be prioritized for action. In a move to halt the decline in service delivery, DANIDA promised direct budgetary support to all districts in early 1993, and this heralded a change in the pace of the decentralization process. Although expansion of the trial project had been planned to proceed gradually to include additional districts, the promise of funding led to a feeling that *"rather than doing this piecemeal, rather than having 9 districts or 18 districts with decentralized budgeting, why don't we try to put something together that would use the Danish funding as its main financial base, which would pick up on some of the procedural and organizational instruments which*

we have been developing in these three districts and so on, and let's have a nationwide approach which would reach all districts" (interview data, former donor representative).

The DANIDA funding came with three preconditions: in each district, (1) the DHMT should have received basic training in planning and budgeting; (2) a person should have been appointed as accounting officer; and (3) a bank account should have been opened (interview data). As a result, the DCB process took off in February 1993. A group of central facilitators was trained using a combination of local and international methods: a WHO problem-solving methodology previously used both in-country and in Ghana, planning tools developed in the Western Province PHC program, and basic costing and budgeting techniques (interview data). The central facilitators in turn trained teams from the provincial offices, and three rounds of district workshops were then planned for the year.

At the first workshop, the concepts were introduced to DHMT members and the development of district plans initiated, using the planned DANIDA funding as a budget ceiling. The second workshop reviewed the draft plans developed within the districts during the interim two months, and a larger team of specialists from the vertical programs worked with the DHMT members to strengthen the technical content. The third workshop took place three to four months after the initial disbursements of funds so as to monitor plan implementation and refine the draft plans for the following year. The DCB team, which travelled the country facilitating the workshops, combined both nationals and technical advisors under a Zambian coordinator.

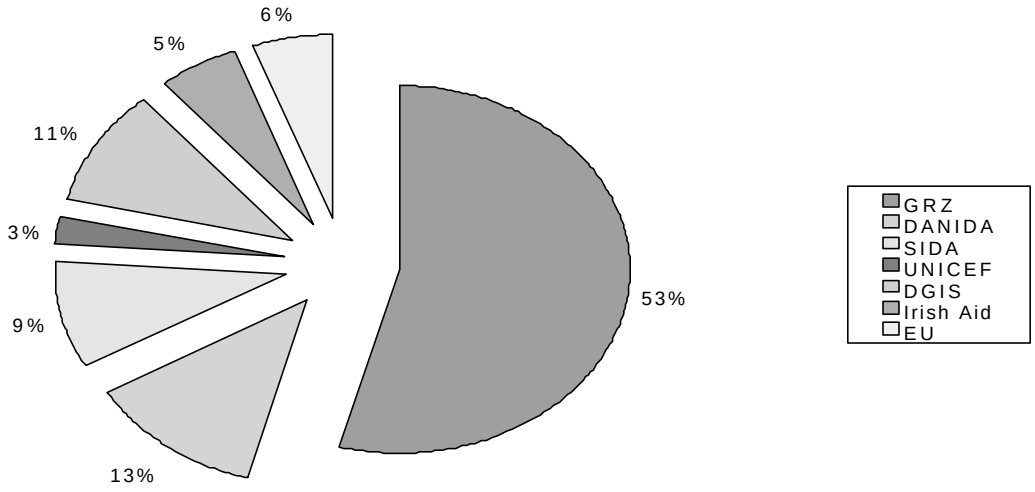
In mid-1993, it had become clear that the original timeframe proposed by the Danish consultants charged with developing the DANIDA support was unrealistic. Kalumba therefore directly approached cooperating partners to seek "bridging funds" to meet the first release of monies to the districts, which was planned for July that year. Funding was provided by a consortium of donors and was widely felt to have maintained both the momentum of the decentralization process and the confidence among districts that this was not merely rhetoric but a more serious government policy (interview data). In turn, the successful disbursement of donor funding to districts led the Ministry to bring forward its own plans to fund district recurrent costs through direct grants from January 1994. The subsequent cofunding of district health services by government and donors has been termed the "district basket" and has been a widely publicized component of the reforms. Basket funding, generally hailed as one of the more successful changes (MOH/UNICEF/WHO/WB 1996), is described more fully in Box 4.1.

Box 4.1. The District "Basket"

The "basket" mode of funding refers to the *"co-financing of district health services by a number of donors and government using a single set of procedures"* (Lake and Musumali 1999). It was developed in response to the growing administrative burden on DHMTs of meeting complex financial monitoring requirements of donors in parallel to the ones being developed as part of the reform process. It also represented a move away from traditional vertical program structures that were felt to be inefficient.

Perhaps the first reference to the concept of a "basket" was when Deputy Minister Kalumba appealed to donors to provide "bridging funds" for districts in early 1993. Four donors stepped in at that point. Since 1995 an increasing number of donors have committed themselves to channelling their financial assistance for district health services in this manner, as shown in Figure 4.4 below. The government remains the major financier, at least in terms of planned support, although broader budgetary constraints have resulted in a different picture of actual funds released.

Figure 4.4. Contributors to the Basket, 1999 Budget



Source: CBOH (1999a)

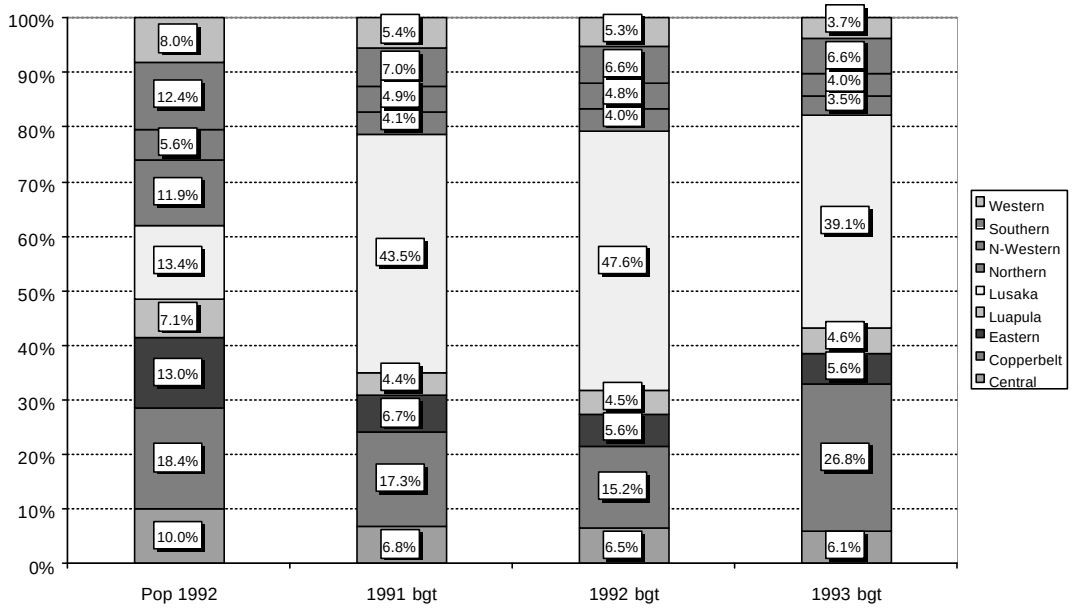
The Basket Steering Committee evolved out of the quarterly MOH/DANIDA bilateral meetings to review project implementation since recurrent budget support had formed a core part of Danish support to the sector. These meetings are held quarterly to review summarized district financial and activity reports and to make decisions regarding disbursement of future funding. Where there are concerns regarding accounting, audit, or technical aspects of plan implementation, follow-up activities are agreed in this meeting and undertaken by CBOH.

With the planned expansion of the "basket" concept to other levels of the health system, as part of the intended move towards a sector-wide approach, the Basket Steering Committee is being redefined as a Health Sector Support Steering Committee (see Section 5.4)

4.5.2 Mechanism for Geographical Resource Allocation

As is the case in many developing countries, sectoral budgets in Zambia have traditionally been determined in an "incremental" manner, whereby historical allocations to specified line items, or inputs, were increased by a percentage to account for inflation. In the early 1990s, however, following questions in Parliament, the Budget Office started *"allocating money to provinces on the basis of allocative criteria; so for primary education it was basically the number of pupils, for police it was population, for agricultural extension it was farming families, so we used some criteria for allocating money"* (interview data, MOFED advisor). Although population is believed to have been used as the basis for funding health, this does not seem to have been borne out in practice as shown in Figure 4.5.

Figure 4.5. Provincial Population and Budget Shares, 1991–1993



Source: Population data from CSO census projections (CSO 1995); Approved budget data from respective Yellow and Blue Books.[31]

At the MOH annual budget workshop in September 1993, MOFED staff presented figures indicating the range of per capita provincial allocations to health in 1993, as shown in the middle column of Table 4.5. After deductions for salaries, these figures showed even greater disparities, with Lusaka Province receiving only K25 per head (excluding the two central hospitals) compared with K457 in North-Western Province, representing a more than 18-fold difference.

[31] Approved budgets are used here as these would be the initial estimates and therefore would be where any population criteria would be applied. Data includes budgets for provincial medical offices together with central hospitals or other institutions included under the PMO at that time.

Table 4.5. Per Capita Recurrent Budget Estimates for Provinces, 1993

Province	Per capita allocation	Including central hospitals[32]
Central	806	
Copperbelt	254	*1,689*
Eastern	548	
Luapula	876	
Lusaka	396	*2,924*
Northern	402	
North-Western	1,050	
Southern	660	
Western	603	

Notes: Figures are based on estimates of 1993 population using the intercensal growth rate, and estimates of provincial budget from GRZ (1993).

Concern about improved allocation and use of resources was expressed in the MMD health strategy paper - *"Zambians must learn to manage limited health resources in order to maximise quality care"* (Kalumba 1991: 4); *"The Ministry of Health should be invited to redefine its priorities towards peripheral health services and re-distribute its funds accordingly"* (Kalumba 1991: 10) as well as in the original MOH policy document in 1992 -*"The government will also need to consider how to achieve a more equitable mechanism for the distribution of resources for health care."* (MOH 1992a)

One former Minister of Health reiterated the idea that the promotion of equity within this area was a key objective of the reforms: *"I think that was a very very important concept of our health reforms, equitable distribution of resources. By equitable we really don't mean equal; no, equitable vis-a-vis the needs"* (interview data). As a result of seeing the inequalities arising under the provincial budgeting system, it was decided to recentralize control of all funding for health services under the MOH permanent secretary from 1994. This was done both to be able to apply more rational criteria for the geographical allocation of financial resources within the sector and to enable the introduction nationwide of district grants (interview data). *"[I]nstead of the PS in Lusaka spending the money, it was the PS in the province using the money the way he thought was right.…one of the things we did, we broke out of that system which would now allow the districts to hold accounts instead of this PACU business..."* (former Minister of Health)

The need for a transparent, objective resource allocation formula had been raised during the evaluation of the trial project (Bennett 1993: Appendix 4). However, Kawimbe made the first decision regarding criteria to be employed for district grant allocations when he decided that 1994 district grants should be based on population (interview data). It was agreed that other factors would be discussed within the Ministry to determine a more comprehensive system or formula for 1995 and beyond. The Planning Unit took on the task of proposing figures to the Budget Committee, which met later to finalize the MOH estimates for presentation to MOFED: *"So for the first time we were having criteria, some objective measures we could use to distribute resources."* (former Minister of

[32] A recent study of the Lusaka health system showed that 92 percent of outpatients and 93 percent of inpatients at UTH came from Lusaka City, confirming long-held beliefs that the larger hospitals primarily serve their immediate surrounding populations (Atkinson et al. 1999).

Health). The evolution of these criteria over the study period is shown in Table 4.6, with the year referring to implementation rather than design.

Table 4.6. Criteria for District Allocations

Year	Funds to which applied	Criteria
1993 and 1994	DANIDA and other donor 'bridging funds'	$0.54pc in rural districts; $0.27pc in urban districts, on the grounds that DANIDA was also providing drug kits to urban districts
1994	GRZ grant funding (i.e., non-salary, non-drug budget)	District population multiplied by the agreed per capita allocation, with the following weights: ±10% dependent on population density (+10% for low density districts) -20% in districts with a second- or third-level referral facility adjustment for existing infrastructure For first-level referral facilities within the district grants: per bed-day subsidy specified for official beds and cots Mission first level referral hospital (1LR) beds funded at 50% of the GRZ rate
1995	GRZ grants and donor funds passing through the 'basket'	As in 1994 with the addition of: ± 5% according to index of fuel prices (as a proxy for cost differentials) + 5% in districts prone to cholera or dysentery + 5% in districts without a bank and/or service station (as a proxy for general underdevelopment)
1996	All district grant funding	As in 1995 except that cots received 150% of the bed-day subsidy due to exemption of under fives from cost sharing
1997	All district grant funding	As in 1995 except that Mission 1LR beds funded at 75% of GRZ rate following signing of 1996 Memo of Understanding (MOU) 20% deduction for presence of a larger hospital dropped in order for districts to directly contract with such facilities for provision of 1LR services[33]

Source: Lake 1994; Cederlöf 1994; interview data

While the 1994 criteria were determined within the Planning Unit, the proposed formula for 1995 was discussed with district officials at a DCB planning workshop in June 1994. The districts requested the inclusion of an infrastructure element, but this was rejected on the grounds that the existing distribution of health facilities was neither rational nor planned.[34] As indicated in the above

[33] In practice, although this was intended to be applied to all funding, MOH retained the deduction in its calculations and it was therefore effectively applied only to donor basket funding (interview data; MOH and CBOH budget documentation)

[34] As with the UK formula known as "RAWP," or the Resource Allocation Working Party, it was believed to be inappropriate to base allocations on supply-side arguments, although this view has been challenged in Zambia on the grounds that existing infrastructure should be supported with recurrent budget and additional funding be directed at redressing inequalities (Noormahomed 1994).

table, however, there have been de facto adjustments to the formula to reflect existing supply (Cassels and Janovsky 1996).

From early 1994, the grant contained "ceilings" for the proportion of funding to go to each of the three planning levels within the district system (district office, first-level referral facility, and health center/community-based activities). In several districts, predominantly those with mission facilities, the proposed ceiling for first-level referral expenditures was insufficient to meet the specified bed-day subsidy, and the total grant was increased by the difference due to the political sensitivity of issues concerning mission health services.

4.5.3 Level of Care Allocations

While objective criteria were applied to the portion of the budget earmarked for districts, the rest of the budget process has been less clear. In terms of determining the appropriate proportion of funding to go to districts vis-à-vis other levels of the system, decisions have been made on a largely *ad hoc* basis. A process of "bottom-slicing" has been employed, with priority given throughout the period under study to the need to progressively expand the proportion of MOH funding allocated to districts, as indicated in successive versions of the Strategic Plan (MOH, 1996: 85; MOH 1998: 127).

For second- and third-level referral hospitals, decisions have largely been based on the policy objective of reducing the proportion of the MOH budget being allocated to these levels, on grounds of efficiency and equity. This has relied on an assumption that such facilities should be meeting a higher proportion of their costs through cost sharing, although the extent to which this has been possible has depended on other financing policies, as described in Section 4.6.

Initially, once a tentative ceiling for the system level had been determined, the total number of beds in these facilities was then divided into the total for the particular level in order to arrive at a "bed day cost".[35] In 1994 and 1995 this was applied to all beds within a given facility according to its designated level, i.e., a second-level referral hospital would receive the second-level rate for all its beds, regardless of the services provided.[36] However, for 1996, an estimate was made of the number of beds of each level within a given facility, and the appropriate bed-day rate applied. From 1997, funding for all hospitals, including first-level referral, has been based on the population/bed ratios shown in Table 4.7 (interview data, CBOH officials and technical advisors).

Table 4.7. Bed Analysis Used

Level	Population/Bed
First level	1,500
Second level	3,000
Third level	15,000

Source: CBOH (1998)

Since 1998, this has been taken one step further with the allocation for first-level referral beds being passed to districts that are now required to enter into contractual agreements with other

[35] More appropriately a bed-day subsidy, as costs are unknown.
[36] It was on this basis that the 20 percent deduction was made from the grants of those districts with a higher level facility, as otherwise such districts would be double-funded for first-level referral care.

hospitals for the purchase of first-level referral services (interview data). To assist this process, bed analysis tables are included in the annual planning guidelines produced by CBOH, and in late 1999, guidelines on how to budget and contract for first-level referral services were produced for districts (CBOH 1999; interview data).

In 1996, a consultant working on the DFID-supported hospital management project, KANDO, proposed to the Planning Unit a revision of the basis for hospital funding to more accurately reflect workload through the use of patient day equivalents, but to date this has not been taken up (Haddon 1996).[37]

Although there has been discussion within the MOH and CBOH over several years regarding the need to revise the relatively crude mechanism for geographical resource allocation, little work has taken place to date beyond framing of considerations for inclusion in any future formula. The following are among the areas that have been earmarked for future consideration since 1993:

- The need for objective criteria regarding the share of funds to be apportioned to districts relative to referral hospitals
- Incorporation of poverty or vulnerability criteria in district formula
- Linkages with cost-sharing policy and practice
- Problems in "small districts" where administrative costs are high relative to the proposed population-based allocation (Anon 1997; Kalumba et al., 1994; MOH 1997; interview data)

It had originally been planned to undertake such work prior to the finalization of the current version of the Health Financing Policy, but this was later dropped because of time constraints and a change in the MOH position regarding the level of detail to be specified in the policy document itself (interview data). It is generally felt that as the allocation of resources is politically sensitive, CBOH as the technical body should be responsible for initiating proposals for any such revision, with MOH having the final say on its adoption (interview data). In 1999, there was a proposal to establish a working group to discuss issues of resource allocation. This would comprise members from CBOH Commissioning and Systems Development, together with MOH Planning Unit, representatives of the operational levels and others (interview data, CBOH officials and technical advisors). In addition, CBOH had submitted to MOH an initial proposal to revise the formula.

4.6 Cost Sharing Policy Evolution and Implementation Post-1991

The platform on which the MMD government came into power included the (re-)introduction of cost sharing for health services, as stated in the Manifesto, the policy framework paper, and later in *NHPS*. The primary motivation for this at the time was to mobilize additional resources (MOH 1992a; Kalumba, et al., 1994; Kalumba 1997). However, the manner in which cost-sharing mechanisms have developed has followed neither a structured nor a linear progression. From the outset, various analysts have participated in relation to particular discrete aspects of financing policy, with little effective coordination by a specific body responsible for formulating and coordinating policy in this area.

[37] The issue of how best to finance the hospital sector is currently receiving more attention as an explicit task of the recently created Hospital Steering Committee within the MOH/CBOH.

From an initial stated manifesto and policy intention to introduce national health insurance, Zambia has seen the successive introduction of different user fees and prepayment schemes. Attempts to move to a more comprehensive financing policy have only relatively recently received support from the ministry leadership. Successive Ministers of Health have favored different schemes, resulting in policy changes and reversals in line with shifts in political leadership within the ministry. The rationale and methods of introduction and implementation of schemes have been as numerous as the cost-sharing options themselves.

One of the first options considered was that of National Health Insurance (NHI). This had appeared in the MMD manifesto and is believed to have grown in part out of the president's background in the trade union movement (interview data). *NHPS* picked up the idea, which alludes to the need to develop a compulsory, as well as a voluntary, scheme each with its own modality for mobilizing resources from members of the public earning their incomes through diverse means (MOH 1992a). The Corporate Plan refers to a phased approach to the development of insurance, with the HCFWG reviewing recommendations on options in late 1992, a pilot in a district or province, evaluation at the end of a year, and national implementation in 1994-95 (MOH 1992b: 41).

In 1992, a WHO consultant came to Zambia to assess the feasibility of developing NHI. She concluded that an insurance scheme based on employee deductions for those in the formal sector would be the most appropriate way to start the process of introducing NHI in Zambia and that this could be extended to the informal and rural areas by modifying it to suit the client's method of payment. This idea was picked up again in 1994 when the deputy minister, spurred by the need for government to deliver on its election promises, requested that the HCFWG revisit formal sector health insurance as an option for Zambia (Health Care Financing Working Group 1994; interview data).

More recently, the idea of a Public Servants Medical Aid Scheme (PSMAS) has evolved. Following the introduction of fees and prepayment in 1993 and 1994, civil servants raised concerns about making significant out-of-pocket payments for health care despite their conditions of service and the initial circular from the MOH, both of which stated that they should be exempt from such charges (MOH 1993). In response, the Cabinet Office, through the MOH, convened a working group to develop a scheme to cover this particular group (interview data). The group proposed PSMAS, which was intended as an alternative to user fees in terms of a mechanism for resource mobilization. Like other cost-sharing mechanisms, the PSMAS was never intended to cover the total costs of health care. Payroll deductions from public servants together with matching contributions from government were to be pooled with government funds into a PSMAS fund before remittance to the relevant District Health Board on behalf of the beneficiaries. As such, the intent was that it would represent a prepayment rather than an insurance contribution.

Neither the NHI nor the PSMAS option has been developed fully, nor has either of them been implemented. Therefore this study concentrates specifically on user fees and prepayment as the key reforms of focus. The evolution of MOH policy on exemptions is also discussed.

4.6.1 User Fees

Building on the work already undertaken and the MMD manifesto and *NHPS* commitment to looking at alternative means of mobilizing additional resources for the sector, the MOH, through UNICEF, commissioned a consultancy to look at options for user fees. This feasibility study recommended that a flat fee scheme would be an equitable way of implementing a fee-paying policy in Zambia (Arhin 1992). This was in contrast to the differentiated fee structure that CMAZ

implemented at mission facilities, which was later copied, on a small scale, at government facilities in the Western Province. Despite this, the study findings were incorporated into *NHPS* (MOH 1992a).

Because of continuing debate as to whether fees should be introduced in rural areas prior to the improvement of quality and service delivery, the user fee policy was first implemented at the hospital level. In late 1992, fees were introduced at UTH and soon afterwards at other central hospitals as a means of supplementing finances and as a means of enabling government to focus public funds on primary-level services (Shipili 1992). User fees at the referral hospital level were divided into two fee schedules: high cost and low cost. The intended goal for the high cost scheme was to recover costs, while the low cost was expected to provide access to the essential package of health care. An analysis of the fee levels, however, inidcates that they do not recover anywhere near the cost of provision (interview data, MOH officials).[38]

In February 1993, the permanent secretary issued a circular to provinces and CMAZ permitting the charges of fees at lower level hospitals. Implementation however was rather haphazard. Despite the specific instruction to introduce fees at hospital level, some districts took it upon themselves to introduce fees at district health centers as well, thereby missing the opportunity of a phased strategy. No standardization existed in either the type or level of fees introduced, with some districts choosing to implement a flat registration or consultation fee per visit or episode, and others adopting a more fee-for-service approach (Kalyalya et al., 1998). In some provinces fee levels were agreed at meetings of district managers and were implemented in a uniform fashion throughout the area, but this was the exception rather than the rule. The requirement that decisions regarding fee levels, banking arrangements, and specifications on how to handle those unable to pay be cleared with the MOH headquarters does not appear to have taken place.

Revenues generated through user fees were to be remitted to the district level where they were held in an account specifically for that purpose – the district medical fees account. This was justified on the grounds of increased accountability, as it was believed that individual health facilities did not have the capacity to manage funds. Revenue projections were built into district plans and budgets, and facilities could access their funds through submission of a request, sanctioned by both facility staff and community members.

A second circular, issued by the ministry in 1993, stated that 90 percent of fee revenues were to be used for improving patient care, while the remaining 10 percent could be used for staff bonuses.[39] This was Kawimbe's initiative and was seen as a means of overcoming some of the problems of low morale associated with the poor salaries and general shortage of operating funds within the system (interview data).

In early 1994 the new minister, Michael Sata, announced both the introduction of a national prepayment scheme (see Section 4.6.2) and the abolition of fees for drugs on the grounds that these were financed largely by donor contributions. This resulted in some districts increasing the registration and consultation component of their fees in compensation (Kalyalya et al., 1998: 17; Lake 1994).

[38] Note that UTH services had not been costed at the time of the study.

[39] The second circular on cost sharing issued in 1993 specified that 10 percent of revenues should be used for staff bonuses. Unfortunately, researchers were not able to find a copy of this circular. It is referred to in Choongo and Milimo (1995), Kalyalya *et al.* (1998), and by interviewees.

In mid-1994, in recognition of the varied practice around the country, the HCFWG held a meeting at which options for cost sharing, including user fees, were discussed. Four potential objectives of the policy were identified:

- To raise revenues by mobilizing additional funds for the health sector
- To promote efficiency by developing fee structures that would provide an incentive to use more cost-effective levels of care
- To foster equity by allowing fee retention at local facilities, which would improve services and thus benefit poorer households
- To create partnership between the users and providers of health services.

Despite a request that the various objectives of cost sharing be clarified to facilitate revision of the national policy, the meeting merely confirmed that all these objectives were important (HCFWG 1994).

More recent work to refine policy has defined the concept of cost sharing as user contributions towards the basic package, while cost recovery refers to payments for services outside the package (MOH 1997; MOH 1998).

4.6.2 Prepayment

Prepayment for health services as an alternative to user fees was first discussed in early 1993. Following a visit by the then minister and permanent secretary to one area in Lundazi District, where concerns about meeting the running costs of a donated vehicle had stimulated discussion of a local initiative to raise the money through collection of maize, the minister considered the idea of prepayment to be potentially viable for national application. The so-called Mwase Mphangwe Initiative (MMI) envisaged household contributions of a 90kg bag of maize at harvest time, and this would cover access to health services at the local clinic for one year. The collected maize was to be converted into cash for use by the health center.

An initial approach to WHO and UNICEF for support of this initiative led to a consultancy to assess its feasibility; however, the timeframe did not allow implementation during the 1993 harvest season, and the removal of Kawimbe as minister at the start of 1994 removed MMI from the immediate policy agenda: *"...by the time I left the Ministry really by and large we were just discussing the consequences, what will this mean? But really…we never had the opportunity to implement the MMI and I don't know, my guess is that my successors probably didn't understand the concept."* The concept of payment in-kind, however, remained on the policy agenda (HCFWG 1994; Kalumba et al., 1994).

Early in 1994, following his appointment as minister, Sata called a meeting of health workers from all districts, hospitals, and the central level in Lusaka. At this meeting, he unilaterally declared the introduction of a national prepayment scheme to begin initially at the three central hospitals: UTH in Lusaka, and Ndola and Kitwe Central Hospitals (interview data). The scheme's purpose was to provide a cheaper alternative to the user fees, which he felt were too high to be affordable to many people. He made suggestions as to the level of charges and the benefit package, and he convened a working group to finalize the proposal (interview data). This group was comprised largely of the

executive directors of the central hospitals and others from UTH, together with the then executive director of the Zambia Flying Doctor Service. The Planning Unit was notably absent.

Although it had been the intention of the Ministry to renew its focus on financing issues in 1994 (interview data), the prospect of a national prepayment scheme to be implemented from April 1 provided the immediate impetus for the reconvening of the HCFWG. This was facilitated by a change in pace and mode of the District Capacity Building work, which had occupied a number of middle MOH/HRIT managers and technical advisors during the previous year (interview data). The first meeting was held in February 1994, where it was agreed that the group should focus on assessing feasibility and operationalization of the prepayment as its first priority, with other financing issues to be addressed later.

A major concern of the HCFWG at this time was the top-down nature of the declaration, given the policy of devolving decision making to districts. A first activity was therefore to send out a discussion paper to DHMTs requesting their feedback on the proposal and their input into the design of a scheme that might work in their area. Only 11 of the 61 districts responded, possibly due to the existing burden of their new roles and responsibilities. HCFWG drafted a proposal for Sata recommending immediate sensitization of the public towards the concept of prepayment, together with a pilot in selected districts that could be evaluated at the end of the year prior to full-scale implementation. This proposal was ignored, however, and the minister informed the executive director of UTH that he was coming to officially launch the scheme in mid-April. A similar process occurred in the Copperbelt shortly afterwards, with the provincial minister carrying out the official launch. The scheme was therefore initially implemented at tertiary level hospitals, with the premium of K500 for an adult and K50 for a child between 6 and 15, at a time when the user fee was K4,500. Prepayment was subsequently extended to the three districts in which the central hospitals were located, initially at the same premium level. The hospitals later increased the charge in an attempt to encourage registration at lower level facilities.

In June 1994 the World Bank raised concern, through a leaked letter to the Minister of Finance, that the scheme was *"...contrary to the letter and spirit of health reforms and strategic plan. Collection of funds also does not seem capable of guaranteeing immediate improvement in quality health care"* (Sunday Times, June 19, 1994). This last comment was due to the observation that revenues at UTH had fallen since introduction of the scheme, creating fears that government would need to raise the level of subsidy to UTH and other hospitals implementing prepayment, thereby reducing funding to the district level as planned. As a result, at MOH meetings in June and July, it was agreed to restrict the scheme to the major hospitals in the form of a "pilot."

No evaluation was undertaken, however, and in 1995 and 1996, there were calls to redesign the prepayment scheme because there was evident moral hazard and misuse of the health system (Atkinson et al., 1996). Unable to make recommendations for its refinement and improvement, the HCFWG left the Prepayment Scheme for later discussion pending its scientific evaluation.[40] No evaluation was ever undertaken due to the close identification of Sata with the scheme and the unwillingness of MOH officials to sanction such an activity. In 1996, after Kalumba became minister, the scheme was restricted to the district level as the hospital outpatient departments were closed.

[40] Minutes of the HCFWG meeting, May 11, 1995.

4.6.3 Exemptions

As already referred to in Section 4.4, early policy documents stated the need for everyone receiving an income to contribute toward health care. However, in a country where the majority of the population is employed either in the informal sector or in subsistence agriculture, the design of mechanisms both for obtaining payments and for determining who has an income is complex.

The 1993 circular specified a number of categories of patient or service that were to be exempted from fees:

- The physically and mentally handicapped, the very poor, and the very young (in general)
- Students who produced a referral letter from their institution
- Employees of the MOH or mission hospitals and their nuclear families
- Government employees whose conditions of service entitled them and their families to free medical care[41]
- Patients with infectious diseases like TB, measles, cholera, and dysentery
- Preventive services such as immunization.

In addition, the circular stated that patients requiring frequent medical attention, e.g., because of hypertension, diabetes, and AIDS, should be considered for special low fees.

Early work assessing the implementation of fee policy and its impact on utilization and access indicated that this policy was not being effectively communicated or enforced. Milimo's presentation to the August 1994 cost-sharing workshop (Health Care Financing Working Group 1994) and Kahenya and Lake's report (1994) both indicated that people were being turned away from receiving health care. This area was debated by the HCFWG, and in 1995 the ministry issued another circular clarifying the following services and population groups to be exempted from both user fees and the prepayment scheme then in operation (MOH 1995):

- Children (0-6) and the elderly (65 and over)
- Antenatal clinics, under-five clinics, TB contact tracing, and STD screening
- Individuals suffering from chronic conditions such as asthma, TB, hypertension, and diabetes
- Populations during disease outbreaks such as cholera, dysentery, measles, and meningitis.

In addition, *"people who cannot afford to pay for health services because truly they have no means"* were identified for assistance through the Public Welfare Assistance Scheme (PWAS) (see below) (MOH 1993).

[41] though the Ministry hoped to recover costs for this group from the Ministry of Finance, in a precursor to the PSMAS

In early 1995, due to growing evidence of the failure of exemptions based on ability to pay, UNICEF commissioned a consultant to examine mechanisms for exempting the poorest, and a working group comprising staff from the MOH and the Ministry of Community Development and Social Services (MCDSS) was established. The practice of the MCDSS Department of Social Welfare (DSW) at that time required a social worker to accompany the patient to the health facility to confirm that the person was entitled to free treatment. It was therefore decided to pilot the incorporation of health services into the existing PWAS.[42] A local consultant was engaged to work with DSW, and nine districts were identified, one in each province. The scheme was known as the Health Care Costs Scheme (HCCS), and it involved a number of stages:

- Identification of "vulnerable" people through existing Ward Welfare Assistance Committees or health facility staff;
- Referral to the District Welfare Assistance Committee (DWAC);
- Receipt of a HCCS certificate on approval by the DWAC;[43]
- Transfer of an agreed amount per identified person from the DSW to the DHMT.

The intention was that the transfer between ministries at the district level would act in the same way as prepayment at the facility, and as recipients were registered with their nearest health facility, the transfers would be considered in the same way as fee or prepayment revenues. The pilot ran for two years—1995 and 1996—and was overseen by a Steering Committee comprising members from the two host ministries, HRIT, UNICEF, the Finnish International Development Agency, CMAZ, and a national NGO, the Program Against Malnutrition. An evaluation at the end of the period found that there were significant problems in terms of targeting the poor and ensuring that those registered had access to basic health care (Ponga and Chileya 1997). Further development and extension of the scheme has since been delayed by the decision within the MCDSS to incorporate HCCS more fully into a restructured PWAS, with the latter process taking significantly longer than anticipated.

4.7 Summary

This section has outlined the evolution of health financing policy in Zambia. It has shown that, both generally and in terms of the selected reforms of focus, the process has been chequered. From a relatively clear, albeit broad, policy position at the time of the change of government, it can be argued that surprisingly little progress has been made to finalize a more comprehensive and operational policy spelling out the relationship between the organizational and financing reforms and between different financing mechanisms. By the end of 1999 the official MOH health financing policy had still not received Cabinet approval, despite a five-year on/off process of consultation and drafting.

This section has described the different manner in which cost sharing and resource allocation reforms have evolved. The primary objective of cost sharing (revenue raising versus partnership with users) and the preferred modality (user fees versus prepayment in cash and/or in-kind) have changed

[42] At the time PWAS provided food, shelter, clothing, and education costs for "vulnerable" people identified through a system of referrals from Ward Welfare Assistance Committees.

[43] Although the intention had been to integrate health costs into the existing PWAS, in practice, approval procedures were deemed too slow, and separate certificates were therefore issued to HCCS beneficiaries. This was due in part to the fact that approval for PWAS funding entailed a larger subsidy/outlay by the DSW, and severe funding constraints therefore limited the speed at which the "vulnerable" could be approved.

within the study period. Pronouncements have been made on a seemingly *ad hoc* basis by a succession of ministers, and official guidelines for providers and users have only recently been issued. Resource allocation reform on the other hand, while initially taking place within the context of sectoral decentralization, has been characterized more recently by a broad lack of activity, despite the acknowledged need to refine existing mechanisms. In contrast to the cost-sharing reforms, progress in this area appears to have been driven by technical officials more than by politicians.

A large and varied number of players has been involved in policy development and implementation since the change of government. These have included both national government staff and technical advisors, many of whom have changed over time with the creation of new institutions such as CBOH or the completion of contract periods in the case of external advisors. Similarly, the turnover in ministers, and the role that each minister has played in health financing reform, is worthy of further examination. While managers have been involved in selected processes, generally the role of providers and users of the system has been quite limited.

The following section discusses the impact of the reforms of focus in terms of equity, sustainability, and their stated objectives. The implications of some of the aspects of policy evolution outlined above on that impact are further discussed in Section 7.

5. Impact of the Reforms of Focus

Given the ongoing nature of policy development within the reforms of focus in Zambia, periodic analysis of their impact is necessary. However, setting suitable benchmark periods or indicators to facilitate comparison of the pre- and post-reform situation is often problematic as it requires establishment of a counterfactual. Because the *ceteris paribus* assumption that economists favor rarely holds in practice, it is thus difficult to ascertain whether or not things would have been better with or without the policy changes. In addition, a key difficulty with some policy reforms (e.g., cost sharing) is that even if they had been introduced at one time, the practice of implementation has varied across the country. As such it is difficult to say for the country as a whole what the overall effect has been.

Despite these restrictions, this section will attempt to explore the impact of the health financing reforms by assessing the degree to which they have achieved their stated objectives as well as their contribution to enhancing equity and sustainability within Zambia's health care system. Impact is examined using a combination of primary analysis of available data together with a summary of evidence from other studies conducted on the subject.

This section is organized as follows: first, the objectives of health financing policies are highlighted together with the approach that has been adopted to analyze the policy impacts; next, the impact of the cost-sharing reforms on equity and sustainability is considered. Section 6 makes a similar assessment for resource allocation reforms. Some limitations of the data and the analysis are outlined in Section 6, which concludes with an overall view of successes and failures of Zambian health financing reforms in terms of the chosen policy objectives.

5.1 Defining Impact

Although Section 2 provides an introduction to the specific concepts used in the assessment of impact, they are revisited here in the Zambian context. Both equity and sustainability are key objectives of Zambia's overall health reform process, and they appear in a number of policy documents in specific reference to health financing. For example, *National Health Polices and Strategies (NHPS)* states that, *"...the challenge for health systems is to establish sustainable financing systems that will consider equity as well as sufficient beneficiary involvement"* (Ministry of Health 1992a: 58). Recent versions of the Strategic Plan refer to a specific vision for health financing reform: *"to mobilise resources through efficient and sustainable means, and to ensure efficient use of those resources in order to promote equity of access to cost-effective, quality health care as close to the family as possible"* (MOH 1998: 111).[44] "Equity of access" also forms part of the overall reform vision, and, within *NHPS*, there are references to the need to achieve *"equity of health opportunities"* (MOH 1992a: 59). In Kalumba's forward to *NHPS*, sustainability is referred to both in terms of finances and in terms of human resources (MOH 1992a: iv).

Table 5.1 lists the specific indicators used in the study.

[44] It is interesting to note that the version of this statement that appears in the June 1996 version of the *Strategic Plan* refers to "guaranteeing" rather than "promoting" equity of access (MOH 1996: 78)

Table 5.1. Financing Policy Objectives and Criteria for Assessing Policy Impact

Objective	Criteria Used to Assess Impact
EQUITY	
Improve access to quality health care	Change in level of utilization at health facilities over time Change in pattern of access to health care benefits by different groups Change in pattern of geographical distribution of health care resources at various levels of health care.
SUSTAINABILITY	
Increase the financial viability of the MOH	Change in cost-recovery ratios
Improve organizational capacity of local authorities (districts)	Increased evidence of relevant skills Increase in local decision-making capacity, especially in financial management
Improve efficient use of resources	Increased accountability in management of funds Improved allocation to different levels of health care system

5.2 Cost-sharing Reforms

5.2.1 Data and Definitions

This study has included only a limited component of primary data analysis regarding the equity and sustainability impacts of cost-sharing reforms. In terms of the equity impact, analysis was largely based on the data series obtained from the Food Security, Health and Nutrition Information System (FHANIS) maintained by the Central Statistical Office. Unfortunately, the data series is incomplete over the period of analysis, and therefore only broad conclusions could be drawn regarding the direction of utilization.

In terms of quantitative data on financial sustainability, the major problem has been that the information systems intended to generate such information are still at a developmental stage. This meant that in some cases the necessary data were not available; for example, data showing the contribution of cost sharing to facility income, or information regarding the change in cost-sharing revenues as a proportion of district and sectoral income over time. However, the primary analysis undertaken using these sources is supported by review of secondary data and, where relevant, has been supplemented by interview data.

5.2.2 The Equity Impact of Cost Sharing

Overall, the available data suggest that the introduction of cost-sharing measures reduced access to health care services. This was reflected in figures showing a decline in health service utilization and in the high proportion of individuals not using any source of health care when ill. These problems may also reflect other factors such as declining household income levels and declining quality of services. Financial access appears, however, to have been protected to some degree for some groups as a result of the exemption policy. Relatively high proportions of children under five and the elderly did not pay for care in 1996, and there were some indications that in some age groups

the lowest income groups were more likely not to pay than the highest income groups. Nonetheless, there were clear signs that some in the higher income groups benefited from exemptions.

5.2.2.1 Impact on facility utilization as a proxy for access

To provide some impressionist effects of health financing policy on the utilization of health services, data compiled from FHANIS were analyzed. These data sets record monthly outpatient attendances from selected health facilities. Data from 1992 to 1997 were available, and information was collected for 39 randomly selected health centers—an average of four from each of the nine provinces. Table 5.2 summarizes the pattern of utilization in these health centers over the period since the introduction of fees.[45]

It should be noted that there are some months for which data were not available for various health centers, and such gaps therefore made it difficult to adopt rigorous statistical analysis of the impact of cost sharing on utilization equity. Neither was it possible to determine at what point cost sharing was introduced in the facilities covered in this analysis. Data were compared with 1993, based on the assumption that most facilities introduced fees during that year, following the issuing of the first official circular. Because of such data problems, conclusions regarding the impact of cost sharing on utilization are drawn from a broader analysis of secondary data from studies that have been conducted in this area in Zambia.

Table 5.2. Pattern of Utilization in 39 Randomly Selected Health Centers in Zambia (1993-1997)

Users	Decline in Utilization	No Significant Change in Utilization	Increase in Utilization	Total
Under fives	27	9	3	39
(%)	(69.2)	(23.1)	(7.7)	(100)
Others	28	8	3	39
(%)	(71.8)	(20.5)	(7.7)	(100)

Source: Data from FHANIS, Lusaka

Note: Numbers refer to facilities in each group, while figures in brackets are percentages.

Table 5.2 shows the pattern of clinic attendances of two groups: children under five and others. Of the 39 health centers sampled, 69.2 percent and 71.8 percent recorded a decline in utilization for children and children above five, respectively. Of the health centers sampled, 23.1 percent and 20.5 percent revealed no significant change in the rates of utilization, while attendance increased in only three of the 39 health centers for both age groups. This suggests that following the introduction of user fees in the health care system, utilization for all users declined below the pre-reform levels at all but three of the health centers. Other things being equal, this implies that financial access was reduced, and thus there was an adverse impact on equity.

The evidence from this analysis is in line with international literature and reaffirms similar findings on the impact of user fees on utilization of health services (at least at health center level) in a number of developing countries (Forsberg 1990; Gilson 1997).

[45] Although it was not possible to determine exactly when fees were introduced in the 39 health facilities included in this analysis, in general, fees were introduced at the health center level during the second half of 1993 or during 1994 (Kalyalya et al., 1998).

Evidence is also drawn from other studies in Zambia to support the assertion that the introduction of user fees around the country has tended to reduce health service utilization. Table 5.3 summarizes the findings of some of the empirical studies on utilization that have been conducted since the broad reintroduction of fees in public health facilities in 1993. The overall picture is one of an initial reduction in utilization, although the magnitude of the decline has varied according to the fee level and the perceived level of quality of care. Although the sample is small, mission facilities appear to have suffered less than government facilities, perhaps because they are often seen as offering "value for the money." With independent drug supplies and varying recourse to additional funds from external donors, mission facilities are often somewhat shielded from the full effect of declining government budgets.

Despite the overall picture of a decline in utilization in government facilities, limited data from some of the studies suggest that more recently utilization rates have stabilized and may even have risen over time (e.g., Daura et al., 1998; Sukwa and Chabot 1996).

The impact of user fees on inpatient admissions seems to have shown a similar pattern. For instance, University Teaching Hospital (UTH) data on admissions for the period March to July 1992 and March to July 1993, i.e., before and after the introduction of user fees, respectively, reveal a substantial decline in admissions after inpatient charges had been introduced (Shipili 1993). This pattern was reinforced by a corresponding increase in the number of bodies "brought in dead" at UTH, rising from a total of 900 between March to July in 1992 to 1,509 over the same period in 1993. This suggests that people were perhaps no longer able to access health care (inpatient services especially) because they could not afford it. The instances of unclaimed corpses also increased after the introduction of user charges as people failed to collect the bodies of their deceased for burial because they could not afford to pay mortuary charges and other related costs (Shipili 1993, p30). Similar declines in admissions following the introduction of user fees have been documented in a number of hospitals in Zambia (Booth et al., 1994; Kalyalya and Milimo 1996; Kalyalya et al., 1998).

Although few studies have been conducted to specifically evaluate the impact of the prepayment scheme, evidence suggests that while fees led to a significant decline in service utilization, prepayment has had the reverse effect. In their study on the Copperbelt, Seshamani and Mwanza (1996) found that *" the introduction of the prepayment scheme in the mid-1994 has to some extent served to mitigate the adverse impact of user fee introduction a year earlier and evidently attendance rates picked up thereafter, although they are still less than the pre-June 1993 levels."* A case in point is that of Kwacha clinic in Kitwe. Clinic attendance had declined following the introduction of user fees between 1993 and 1994. After prepayment was introduced in May 1994, attendance increased by 92 percent by December the same year. A similar recovery was recorded at Kitwe Central Hospital where attendance had declined when user fees were introduced. Kitwe went from 128,451patients in 1992 to 75,061 at the end of 1993, but increased to 83,348 by 1995 following the introduction of the prepayment scheme.

Table 5.3. Reported Utilization Effects of Cost-sharing Reforms

Study	Scope	Cost-sharing reform	Utilization effect noted	Other comments
Shipili (1993)	UTH	User fees	Reduction in admissions Increase in 'brought-in-dead'	
Kahenya and Lake (1994)	12 Lusaka urban clinics	User fees	Substantial reductions in OPD attendances in urban clinics (44% for general OPD; 76% for STDs) Reductions sustained over the year in several clinics Smaller falls for services with lower fees (e.g., 19% for under-fives and antenatal care)	Introduction of prepayment at clinics in mid-1994 reversed this trend
Booth et al. (1994)	Rural sites in Lusaka Rural, Chipata, and Senanga urban compounds in Mongu and Ndola	User fees (the study took place just after the introduction of prepayment in Ndola before impact could be assessed)	Outpatient attendances at Kamoto mission hospital, Jumbe fell from a peak of 3,500 in March 1989 to 500 in August 1993 and were still under 1000 at the time of the study OPD attendances at Lewanika hospital in Western Province in May 1994 were 1/3 of their May 1993 level. Among those who attended in May 94, the proportion of patients from the poorest compound had fallen. Senanga district hospital and Mtendere mission hospital both showed initial drops but recovered fully within the year Twapia clinic in Ndola showed a drastic fall in OD attendances following the introduction of fees with no recovery within the year	Senanga DH benefited from Dutch TA and financial support to PHC, and Mtendere MH was perceived as offering 'value for money'
Kalyalya and Milimo (1996)	Sites in two rural (Chongwe and Senanga) and two urban districts (Kabwe and Kitwe)	User fees	OPD attendances progressively lower 1992 to 1994 at Kitwe Central Post Feb. 1994 OPD attendances at Garnerton urban clinic in Kitwe higher than in 1993 Substantially lower OPD attendances at Chalimbana and Chainda rural HCs in Chongwe district in 1994 compared with 1993	Effect of higher fees at the hospital may have encouraged greater use of the clinics, as had been intended
CHESSORE (1996)	3 districts in each of 4 provinces (Copperbelt, Eastern, Northern and Western)	User fees	A reduction in attendances since the introduction of fees was reported by 63% of DHMT members, 52% of administrators, 52% of health workers, and 71% of community members interviewed	No actual calculation of attendances was reported, so these findings are impressionistic rather than evidence-based

Atkinson et al. (1996)	Lusaka Urban	User fees and prepayment (referred to as medical insurance scheme)	"A widespread dramatic drop in the numbers attending the clinics was reported by the in-charges when user fees were first introduced. By comparison, with the introduction of the medical insurance scheme, the numbers attending has picked up markedly and are almost back to prepayment levels at some clinics". (p32)	The study did not involve calculations of utilisation, but interviews and FGDs with staff, users and community members.
Sukwa and Chabot (1996)	Ndola Rural, Sereenje, Kapiri Mposhi	Not specified	24% decline between 1994 and 1995 in Ndola Rural health centres, with a projected further fall of 5% in 1996 Projected increases in Serenje and Kapiri health centres in 1996 compared with 1995 18% and 37% increases in OP attendances at Kafulafuta mission RHC in 1994 and 1995, with a projected further increase of 16% for 1996	
Daura et al. (1998)	2 urban (Kitwe, Lusaka) and 3 rural districts (Lundazi, Mazabuka, Mongu)	User fees and prepayment	The first half of 1994 saw a fall in utilization in several facilities but, in all except in Mazabuka, these had subsequently regained their early 1994 levels Recent smaller increases in fee levels had had little noticeable effect Utilisation increased most in Lusaka and Kitwe where OP Depts at hospitals had been closed in 1996	

Although these figures seem impressive, one needs to be extremely careful in interpreting these statistics. Flaws in the design and implementation of the prepayment scheme encouraged "moral hazard" such that patients mostly used the prepayment scheme at the time that they sought health service with limited subsequent use (Atkinson et al., 1996 — see Section 6). Thus what may appear to be a desirable increase in utilization may actually be considered "frivolous" and detrimental to the attainment of the efficiency and equity objectives of the health financing reforms.[46]

5.2.2.2 Removing barriers to access – the impact of exemption policies

Realizing that the introduction of fees and prepayment may cause barriers to access, the MOH has always had a complementary exemption policy in place; however, the categories of people exempted have changed over time (see Section 4.6.3). In addition to exemptions based on age, public health, and preventive services, the pilot Health Care Costs Scheme (HCCS) was intended to assist vulnerable persons in accessing health care, and in the 1995 circular, a Disaster Fund was proposed to cater for victims of such events as floods or drought (MOH 1995).

Table 5.4 provides 1996 data on public health facility utilization. These data suggest that there were few signs of gender inequities in the pattern of access to health care across the seven provinces surveyed and across age groups; however, although there were higher levels of utilization among the vulnerable under-five age group than other groups, the elderly population appear to have used outpatient care very little.

Table 5.4. Percentage Distribution of Outpatient Cases by Age, Sex, and Province in Health for the Period between April and July 1996

Province	Less than 5 %		5-14 %		15-24 %		25-34 %		35-44 %		45-54 %		55 and above %		Total
	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Central	13.2*	15.6	6	5.4	8.1	13.4	8.6	10.7	4.1	7.2	1.7	2.9	1.5	1.7	8,358
Copperbelt	32.6	15.0*			6.5	6.5	6.4	6.5	5.3	5.5	4.4	4	3.4	3.9	14,316
Eastern	37.7	30.7	8.4	6.1	5.9	4.5	7.1	5.2	2.6	2.1	1.9	1.2	1.3	1.1	3,798
Lusaka	20.6	21.6	6.7	7.1	11.4	8.1	7.8	5.5	3	2.5	1.5	1.5	1.7	1	2,724
Northern	27.7	26.3	6	4.5	7.6	5.9	4.7	4.5	2.3	3.8	1.5	1.6	1.2	2.1	2,964
Western	18.9	15.9	7.1	5	10.7	8.4	7.4	5.6	5.7	4.4	2.4	2.3	2.7	3.5	3,790

Source: CBOH (1997).

Notes: Data were collected from health registers and records. No data for North-Western or Southern Provinces.

- Indicates data from registers/records incomplete and unusable for required analysis

* Under 1 year only as 1-5 not available

Table 5.5 presents 1996 household data derived from the Living Conditions Monitoring Survey (LCMS) that shows the percentage of sick individuals who sought care as well as the provider used during the two weeks prior to the survey.

[46] This is much more likely to be the case in the urban areas where the prepayment scheme was introduced than in rural areas, given the relative proximity of facilities.

Table 5.5. Percentage of Sick Individuals Who Sought Care and Provider Choice During the Last Two Weeks Preceding the Survey by Income Group

Income Group	Did Not Use	Did Use	Govt Hospital	Govt Clinic/Health Center	Mission Institution	Industrial Institution	Private Institution	Traditional Healer
Quintile 1	61.94	38.06	4.49	25.53	3.96	0.96	0.3	1.17
Quintile 2	62.06	37.94	4.73	24.14	3.93	0.07	0.82	1.17
Quintile 3	56.64	43.36	8.43	25.22	4.91	0.69	1.32	1.13
Quintile 4	53.63	46.37	10.92	24.79	7.66	3.61	2.1	1.28
Quintile 5	48.47	51.53	13.96	19.91	15.5	9.34	2.15	0.5
Total	**57.1**	**42.9**	**8.13**	**24.1**	**6.69**	**2.52**	**1.76**	**1.08**

Source: Diop et al., 1997

Note: Quintile 1 is the lowest income group, while quintile 5 is the highest.

The continued existence of effective barriers to access, despite exemption policies, is clearly demonstrated by the data on those who did not seek health care. Over half the respondents did not seek care at all when sick, and there was a clear income differential amongst this group. The probability of not seeking care was 28 percent higher among those in the lowest income quintile than in the highest. The table also indicates that the lowest income groups were most likely to seek care from a government clinic or health center compared to other health care providers but that the proportion using this facility type was roughly similar across all except the highest income quintile. In contrast, and again possibly reflecting the barriers to access faced by the lower income group, the probability of the lowest income group using a government hospital was almost three times lower than that of the highest income group. The lowest income group was also almost four times less likely to use a mission institution than the highest income group. This suggests that although mission services may be seen as offering value for money, their charges do restrict access by lower income groups.

Finally, Table 5.6 provides further evidence on the effectiveness of the government's exemption policy, again using the 1996 LCMS data.

The under-five and 65+ age groups clearly benefited from the exemption policy, having the highest proportions of those who did not pay for care at public facilities across all age groups. About 30 percent of patients in those age groups, however, still reported that they had paid for health care, indicating that the policy is not being enforced everywhere. For these two categories and for those between the ages of 5 and 24, there was no significant variation by gender in the percentage of those who did not pay — in contrast to those between the ages of 25 and 64. More women aged 25 to 44 did not pay while more men in the 45 to 64 age group did not pay. These latter differences may reflect the different morbidity patterns in these age groups and the nature of exemption categories.

Despite their being employed, a reasonable proportion of all such groups considered in the table did not pay for health care. The proportion among the self-employed and government employee groups who received free care was higher across all age groups than for other employed groups. The higher rate of government employees receiving free care may be the result of an early MOH circular, which indicated that government employees should be exempted (MOH 1993). The generally lower rates of private sector and parastatal employees exempted from payment are likely to reflect the fact that many such groups have their health care costs prepaid by their employers.

Table 5.6. Percentage of Patients Who Did Not Pay at Public Health Institutions (i.e., for the last consultation during the last week preceding the survey by age of the patient and socioeconomic characteristics of the household)

	Percentage of Patients Who Did Not Pay					
Categories/Age	**<5**	**5-14**	**15-24**	**25-44**	**45-64**	**65+**
Male	71.86	29.61	16.79	21.00	30.45	68.97
Female	70.65	29.86	14.48	30.86	18.05	63.37
Employment status						
-self-employed	72.67	30.88	17.61	24.50	28.44	69.98
-government	69.92	32.81	16.76	24.96	35.50	3.43
-parastatal	74.39	15.12	15.28	9.39	25.62	-
-private sector	66.57	20.54	9.85	9.00	21.36	-
Income group						
-quintile 1	73.31	40.75	21.57	31.62	35.83	70.29
-quintile 2	74.70	34.98	16.69	25.05	20.98	70.85
-quintile 3	68.44	27.10	15.65	19.58	18.63	67.28
-quintile 4	69.79	20.49	13.86	21.05	39.74	47.38
-quintile 5	72.46	23.74	16.43	17.79	8.89	42.53
Ratio Q1/Q5	**1.01**	**1.72**	**1.31**	**1.78**	**4.03**	**1.65**
All	**71.66**	**29.69**	**16.37**	**22.31**	**28.26**	**67.24**

Source: adapted from Diop et al., 1998, p.74

Note: Q1/Q5 gives the ratio of first quintile to the fifth quintile for each age group (where the fifth quintile = 1).

Finally, although there is variation across age groups, the percentage of people who did not pay for health care at public facilities tended to be highest for those in the first two income quintiles. Those in the lower income quintile were more than one and a half times as likely to not pay as were the highest income quintile in the 5 to 14, 25 to 44, and over 65 age groups, and they were about four times as likely to not pay if they were in the 45 to 64 age group. The proportion of people not paying was roughly the same across all income quintile groups for children under five and was both relatively high and less variable across income groups for the over 65 age group. Even among the 5 to 15 and 25 to 44 age groups, about one-fifth of respondents in the highest income quintile received free care at the time of the survey.

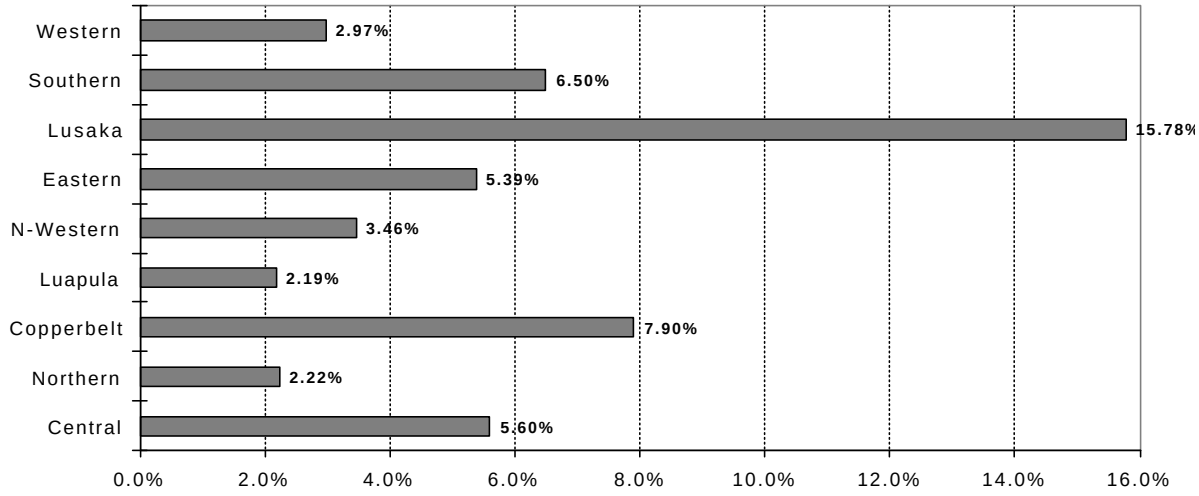
These data suggest that the exemption policy worked relatively well in protecting patients categorized by demographic features, particularly age. There was also some evidence that those elderly in the lower income quintiles were protected to a greater extent than those in higher quintiles, indicating some concern for ability to pay. The practice of exempting certain patients from payment appears to have been applied, however, to a considerable proportion of various employed groups, particularly the self-employed and government employees. Exemption policy therefore seems to have been more successful in promoting demographic equity than in necessarily reflecting payment according to ability to pay.

5.2.3 Sustainability of Cost Sharing

5.2.3.1 Financial Sustainability

With respect to the cost-sharing reforms studied here, reported revenue generation from user fees and prepayment schemes has been relatively low in relation to the cost of providing services. Figure 5.1 presents 1997 provincial data on cost-sharing revenues as a proportion of total district income, where income also includes government grants and donor funding through the basket.

Figure 5.1. 1997 Cost-sharing Revenues as a Percentage of District Income, by Province

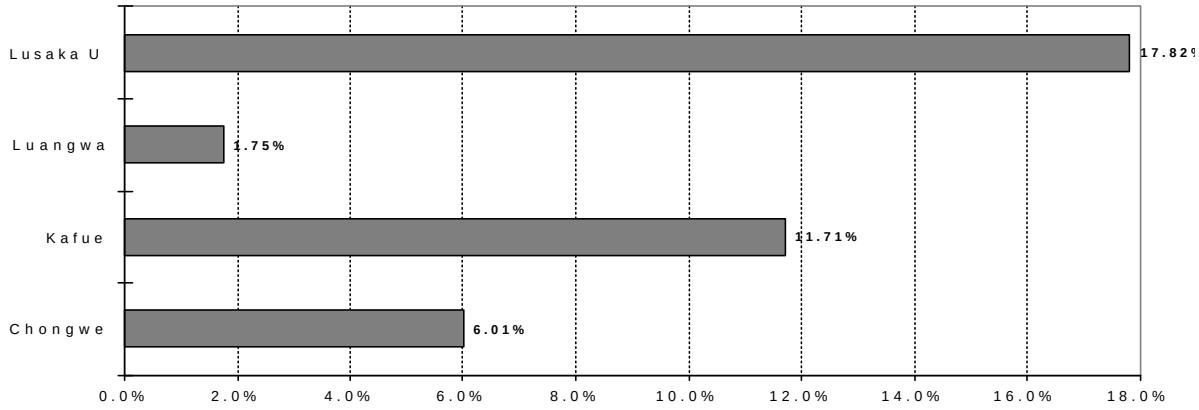


Source: CBOH (1998b) Income and Expenditure Statement

The above graph shows that there is substantial variation around the country, with the urban provinces of Lusaka and the Copperbelt generating the highest proportion of income. According to 1996 LCMS data, the four provinces with the lowest rate of cost recovery are the poorest in the country, with poverty incidence rates of over 85 percent.[47] This tendency is further illustrated in Figure 5.2 by similar district data from Lusaka Province, with Lusaka Urban and Kafue districts being more urbanized than Chongwe and Luangwa.

[47] Poverty incidence is defined as the percentage of individuals living below a poverty line based on income per equivalent adult (CSO 1996: 126). The poverty incidence rates for Lusaka and Copperbelt were 65 percent and 58 percent, respectively.

Figure 5.2. 1997 Cost-sharing Revenues as Percentage of District Income, Lusaka Province



Source: CBOH (1998b) Income and Expenditure Statement

The study by Daura et al. (1998) also indicates that cost-sharing revenues at district level meet about 10 percent of recurrent costs, defined to include the recurrent cost elements of the district grant. This covers expenditures on supplementary drugs, travel costs, non-medical supplies, salaries for staff employed by the district boards (usually clerks, cleaners, and a few medical personnel), staff bonuses, and maintenance costs. According to Sukwa and Chabot (1996), cost-recovery ratios cited for districts around the country are between 2 and 8 percent of recurrent expenditures.[48]

These levels of cost-recovery ratios can make only a small difference to the overall resource needs of the health sector. For instance, it was estimated in 1996 that the annual per capita cost of providing basic primary care services at the district level was about US$12. Given that existing government allocations to the districts averaged about US$4.5 per capita, there is an annual shortfall of US$7.5 per person if donor funding is excluded (MOH/WHO/UNICEF/WB, 1996). Other studies (see Daura et al., 1998; Masiye 1998) have also shown that revenues from cost-sharing schemes have only had a small impact in terms of offsetting the overall financial resource constraint facing the health sector and that donor funding is critical in ensuring financial sustainability. Daura and Mulikelela (1998) found that about 45 percent of district recurrent expenditures were financed from donor grants to the districts.

Evidence also exists to suggest that the limited revenue raised from user fees and prepayment schemes is a useful additional source of funding for districts (Daura et al., 1998; MOH/WHO/UNICEF/WB, 1996; Nzala 1993). An interview with a district director of health in Lusaka Province revealed that funds from user fees and prepayment have helped improve the state of health infrastructure at the local level by allowing the purchase of items such as curtains and the payment of minor repairs. In some cases, fee revenues have also led to improved water and sanitation facilities, transportation services, availability of telephones, coffee for staff, and even drug availability. In talking about one hospital manager, a senior MOH official revealed that, "*… as government funds are so unpredictable, he has decided that he is going to cut down the budget to what he expects to collect [from patient fees] rather than what government allocates…so he can run his [hospital]. And he is doing wonders, and his explanation is that he is tying what he is doing to the fees he collects*."

[48] Although it should be noted that the denominator is not specified, and it is therefore unclear whether this refers to district grant funding only, in which case it would exclude the bulk of salary and drug expenditures.

A further benefit of cost sharing in terms of quality of care is that the morale of staff appears to have been strengthened by the "merit" bonuses paid from fee revenues, as indicated by the second 1993 MOH circular (Booth et al., 1995; Atkinson et al., 1996). A number of sources have speculated, however, that the staff's improved attitude toward patients is due more to the reduction in attendance immediately following the introduction of fees (Kahenya and Lake 1994; Booth et al., 1995).

In general, the evidence about the perceived impact of fee revenue on quality of care is contradictory and limited. Available studies show both improvements and little or no change in perceived quality of care, and the persistent drug shortages that hospitals and health centers face represents a major quality problem that could well undermine any benefits derived from the limited fee revenue (MOH/WHO/UNICEF/WB, 1996).

5.2.3.2 Contribution of Cost Sharing to Enhanced Health Provider Accountability

One of the major impacts of the cost-sharing policy is that it has ended the era of "free" medical care in Zambia. User charges are now an accepted practice, and a culture of paying for services has been initiated. This acceptance of user charges has brought with it a greater concern for the quality of health care among the population. Although several aspects of quality of care have not yet improved (notably drug availability), a number of studies suggest that fees have led the population, media, and pressure groups to be more vocal in their complaints about the quality of care (Daura et al., 1998; Kahenya and Lake 1994; Kalyalya and Milimo 1996; Masiye 1998). Some studies (MOH/WHO/UNICEF/WB, 1996; Daura et al., 1998) also specifically suggest that health providers are now more accountable to, or at least more conscious of, patients' needs because of the bonus incentive that is paid from the fee revenue. The evidence of such potentially positive impacts remains very limited. In addition, there are concerns that the limited financial gains of cost sharing, and its consequent inability to produce tangible benefits for the consumer, may result in decreased morale and participation by the community (e.g., Kalyalya and Milimo 1996; Booth et al., 1995; Daura et al., 1998).

5.3 Resource Allocation Reform

5.3.1 Data Issues

Examining the impact of resource allocation reform has been difficult, largely because data have been unavailable or inaccurate. In some instances, this has been caused by the inevitable time lags in the publishing of government expenditure data, but there have also been issues relating to the politics of releasing MOH expenditure information, which at times has been delayed or even refused. In addition, MOH has not undertaken a systematic analysis of the budget and expenditures for the entire period under study, and there have been frequent changes in budgetary formats and associated assumptions regarding allocations to level of care. A final difficulty has been other changes in data series; for example, the creation of new districts for which populations are not always available.

A further caveat is that the health sector budget extends beyond the MOH (as outlined in Section 3) to budget lines within the Ministry of Defense and the Ministry of Community Development and Social Services, and these have not been included in these analyses. In addition, the analyses below do not include donor expenditures and are, therefore, incomplete. Both these concerns are currently being addressed by the ongoing exercise within Zambia to develop a set of National Health Accounts.

The information presented below reflects two different analyses of resource allocation policy reform impact on equity and sustainability. Published MOH budget figures are used to measure *policy intent*. Two measures of budget exist: the *approved* budget reflects the figures agreed by Parliament at the start of the financial year and included in the so-called Yellow Book; the *authorized* budget includes any supplementary allocations made throughout the year and is taken either from the following year's Yellow Book or from the relevant Blue Book of expenditures. For this analysis, authorized figures were used wherever possible. The study indicates wherever figures from approved budgets have been used (as in the case of 1999 data).

Actual impact of policy reform is measured using expenditure data. The official government publication of expenditure figures, the Blue Book, usually takes over a year to be produced following the end of any given financial year, and it has not been possible to locate or to use Blue Book data in a number of calculations. Also, for the period since 1994 when districts began receiving funds directly, the Blue Book does not indicate the separate amount allocated to each district, but distinguishes only between the budget lines for regional health offices, referral hospitals, districts, and missions. The analysis using district level expenditures has therefore been undertaken using MOH and Central Board of Health data. As the systems are relatively new and still undergoing teething problems, there may be inaccuracies in these data that cannot be identified at this stage; however, the broad conclusions are unlikely to change.

In any discussion of resource allocation, it is necessary to define the scope of different geographical areas or the levels of care under consideration. The core level of the reformed Zambian health system is the district. This includes community-based health workers (where they exist), health posts and centers, any first-level referral hospital facility, and the district office. Health posts and centers are currently staffed by clinical officers, nurses and/or midwives, and environmental health technicians, and generally they offer limited inpatient facilities for deliveries and observation.

The first-level referral (1LR) hospital is what has formerly been called a district hospital (Mills 1990; Barnum and Kutzin 1993; Doherty and van den Heever 1996). It is staffed by a minimum of one general medical officer, and it has a theatre. Ideally, it has X-ray and lab facilities. The second-level referral (2LR) hospital corresponds to the provincial or general-type hospitals, offering the four specialties of internal medicine, surgery, obstetrics/ gynecology, and pediatrics. These facilities accept patients referred from 1LR facilities. They generally also provide 1LR services to the local population. In 1996, the Ministry of Health introduced a policy of closing direct outpatient departments in these hospitals in order to promote more efficient use of the referral system. Up until 1996, there were nine government and five mission hospitals designated as second level. Since then, certain additional facilities have been recognized as having the capacity to provide 2LR services in some specialties but not necessary all.

The third-level referral (3LR) facilities are those sometimes known as central hospitals. There are five such facilities in Zambia, all located in the urban provinces of Lusaka and the Copperbelt. Although designated as national referral hospitals, there is evidence that they primarily serve the immediate catchment population and that their function is primarily as 1LR and 2LR (Atkinson et al., 1999). Various assumptions have been made in the provincial analyses regarding the proportion of budget and expenditures for these 3LR hospitals to be incorporated into the geographical and level of care allocations. These are specified in each case.

5.3.2 Promoting Geographical Equity

Improving equity has always been a key and explicit objective of resource allocation reform in Zambia. As the 1992 policy document stated, *"the government will…need to consider how to achieve a more equitable mechanism for the distribution of resources for health care"* (Ministry of Health 1992a: iv). As outlined in Section 3, this was largely due to the distribution of resources, which, as is common in low-income countries, had been historically skewed in favor of urban, more wealthy areas and toward more sophisticated hospital services (which tend to be concentrated in such areas). At the same time, it was clear that the policy of decentralizing funds through provincial permanent secretaries to redress these inequities had not worked, as shown in Figure 4.4 in the previous section. It was then decided to introduce a formula to improve the equity with which funds were allocated between geographical areas.

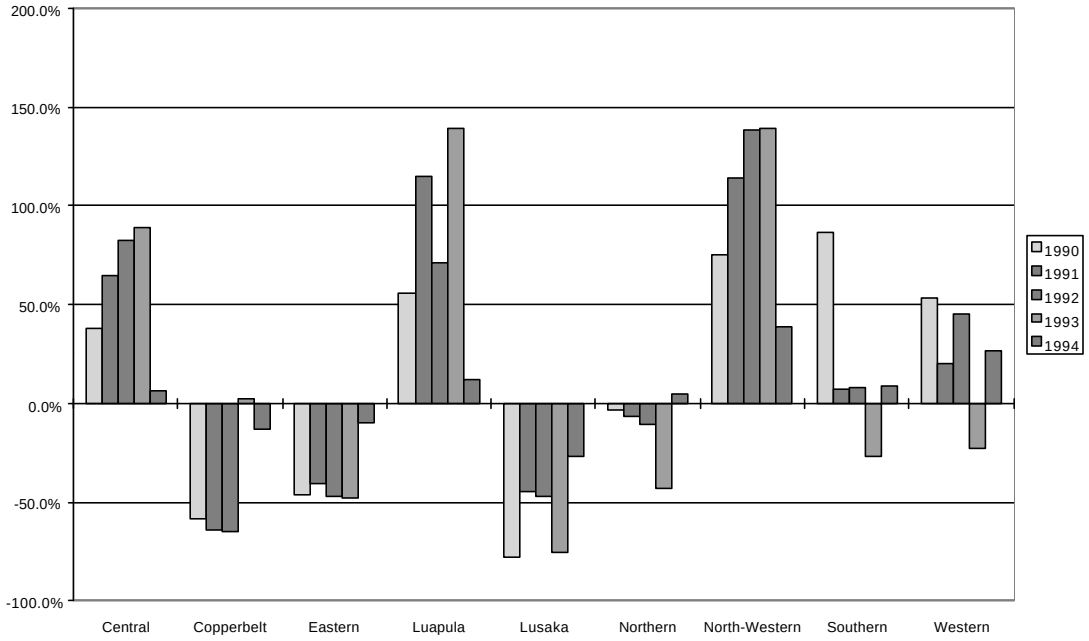
Figure 4.4 indicates that while provincial populations in 1992 ranged from 5.6 percent in North-Western Province to 18.4 percent in the Copperbelt, Lusaka Province consistently received the greatest share of resources over the 1991-93 period, with a massive 47.6 percent going to the capital in 1992. This is largely due to the inclusion of the budget for UTH; however, the exclusion of central hospital budgets from this analysis still shows a distribution unrelated to population, as shown in Table 4.5.

The Zambian formula is intended to improve the equity with which financial resources are allocated between districts rather than between provinces, since this is the chosen focus for the reformed health system. The nature of the budget system in place before 1994, however, makes it impossible to determine the district breakdown of resources prior to use of the resource allocation formula. It is, however, possible to examine the impact of the formula on interprovincial allocations through a comparison of the pre- and post-1994 scenario and also to explore movements in interdistrict allocations within provinces for the period since the formula was introduced.

In this study, equity is defined using a relatively limited concept of equal per capita funding. "Need" is assumed to be incorporated within the budget, and provincial distances from "equity" based on the mean per capita allocation are then presented. The method used is based on the work done in England in the development of a population-based formula for allocation of recurrent funds to regions (Department of Health and Social Security 1976) and later work undertaken in South Africa on similar lines (Brijlal et al., 1997; Makan et al., 1997).

Figure 5.3 shows the trends in provincial allocations excluding 3LR hospital allocations. The provincial figures for 1994 are taken from a summation of district figures within each province and the addition of budgets for the regional health advisors' offices (RHA) and the 2LR hospitals in order to make them consistent with those for the preceding period.

Figure 5.3. Provincial Distance from Equity, Excluding Central Hospitals, 1990-1994



Notes: 1994 district figures based on a different population basis from calculation of equity;[49] budgets include Recurrent Departmental Charges (RDCs) only for all years[50]
Source: 1990-93 authorized provincial budgets from relevant Yellow Books; population data from CSO projections (CSO 1995); 1994 district data from MOH estimates;[51] 1994 Regional Health Advisors' Offices (RHA)[52] and 2LR hospital data from Yellow Book 1995.

This graph shows a situation of increasing inequity, as defined for this analysis, in all but three provinces over the period 1990-1993. In most cases, provinces have been consistently over- or underfunded over the period. In Central, Luapula, and North-Western provinces, there was an increase in relative overfunding, while in Lusaka (1991-93) and Northern provinces, relative underfunding increased over time. The substantial relative overfunding of Luapula Province (almost 140 percent in 1993) is likely to be due to two of the five districts receiving grants under the district budgeting trial (see Section 4.2.2). No explanation has been found for the similar position prevailing in North-Western Province.

Following initial increases in inequity, the Copperbelt showed a significant change, going from being underfunded by more than 50 percent in 1990-1992, to being slightly overfunded in 1993, before returning to a position of moderate underfunding in 1994. Between 1992 and 1993, Western and Southern provinces went from being slightly over-funded to significantly underfunded, before

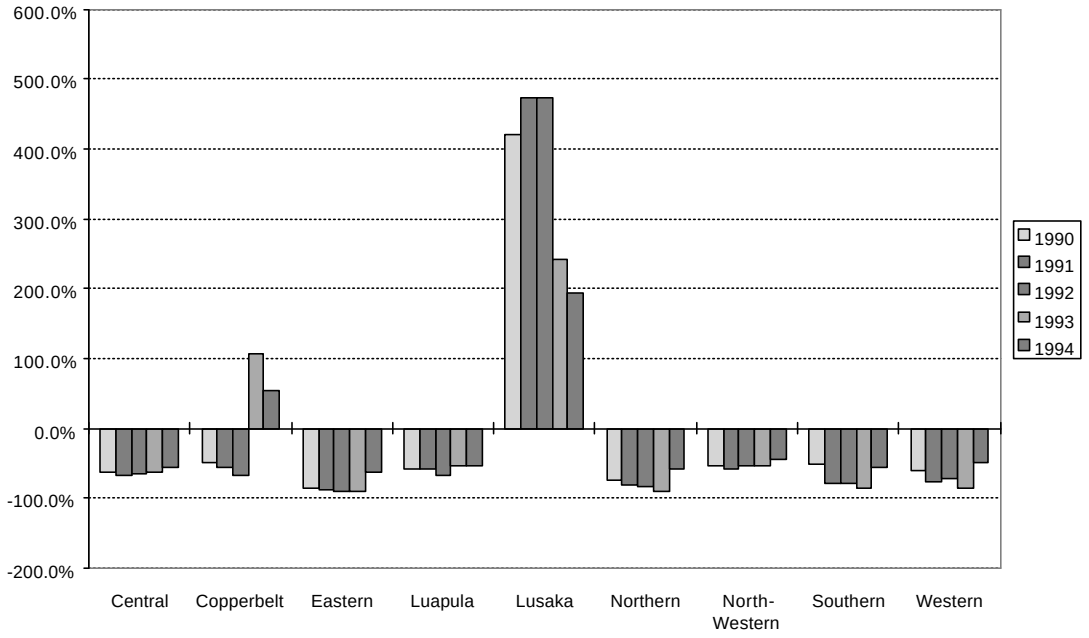
[49] The 1994 district grants were calculated using per capita figures derived from internal MOH population estimates based on provisional census data, while the equity calculations use final census figures.
[50] I.e., personnel emoluments and centrally procured items are excluded. This is consistent across all five years as the district grants also exclude these items.
[51] The district figures are those agreed within the ministry at the start of the year. There are no "authorized" figures as such.
[52] The Regional Health Advisors' offices referred to here are the formerly named Provincial Medical Officers' offices, and they should not be confused with the later Regional Health Directors' offices, which were created with the CBOH in 1996. The former reflected a change in name only, while the latter involved a change in geographical focus.

they returned to overfunding following the introduction of the formula. In Western Province, this might be explained in part by the switch of funding for Senanga under the trial project to Mwense/Nchelenge, but it is not clear why this happened in Southern Province where Monze received funds as planned.

It is clear, however, that the introduction of the per-capita-based formula in 1994 had a broadly positive effect in moving provinces toward a position of relative equity, compared with 1993, reducing the inequities in the previous distribution in all but two provinces. The Copperbelt Province moved from a position close to equity (1 percent under) in 1993 to 13 percent below the line of equity in 1994, while Western Province moved from being relatively underfunded by 25 percent to a position of relative overfunding of almost 27 percent.

With the inclusion of central hospital budgets, the provincial estimates dramatically change the picture of the distribution of financial resources, as shown in Figure 5.4. Again, figures for 1994 are taken from provincial summations of the district budgets and the addition of the authorized budgets for regional offices and 2LR and 3LR hospitals.

Figure 5.4. Provincial Movement Toward Equity, Including Central Hospitals 1990-1994



Notes: Individual district budget figures are again calculated on a different population basis than that used for the equity analysis.
Source: 1990-93 authorized provincial budgets from relevant Yellow Books; population data from CSO projections (CSO 1995); 1994 district data from MOH estimates; 1994 RHA and 2LR hospital data from Yellow Book 1995.

The bias in favor of the urban provinces is clearly illustrated in Figure 5.4, with Lusaka reaching a maximum of almost 500 percent of the mean per capita budget in 1991 and 1992, and the Copperbelt exceeding 100 percent in 1993. These allocations have been at the expense of the more rural provinces, all of which were relatively underfunded during 1990-93 by between 50 and 100 percent. This is largely accounted for by the share of the total budget going to UTH during the early 1990s (see Figure 5.7). The reduction within the central hospital level budget in the allocation to UTH (see Figure 5.8) has relatively favored the central hospitals of the Copperbelt, as reflected in the

movement of that province from a relatively underfunded position in 1990-1992, to one of relative overfunding in 1993-1994.

In most cases, however, the introduction of the formula for district allocations can be shown to have resulted in an improvement in the distribution of funding, with only Central and Luapula provinces showing little change or a slight deterioration in their relative positions. In terms of the impact on geographical equity, the introduction of the formula may be said to have reflected a clear policy impact at least at the level of intent. It is also worth noting that although the figures above refer only to government funding, the same formula is in fact applied to donor funding through the basket (see Box 4.1).

Figure 5.4 includes 100 percent of central hospital budgets within the relevant province. In theory, this figure should be varied according to the proportion of funding which can be considered as serving that provincial population, on the assumption that the hospitals do serve their original purpose as referral facilities. However, as indicated in Section 4.5.2, this has been called into question for UTH at least (Atkinson et al., 1999).

5.3.3 Sustainability through Improved Efficiency

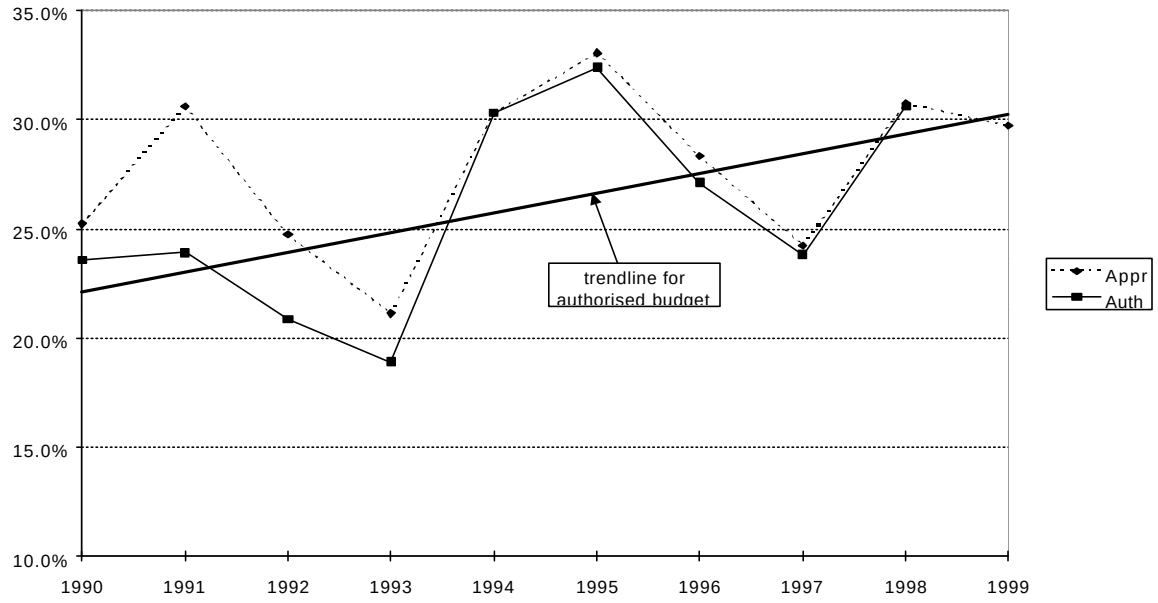
As outlined in Section 2.4, the impact of resource allocation reform on sustainability is measured primarily through change in the allocative efficiency of MOH funding, i.e., improvements in the efficiency of resource use through increasing the proportion of the health budget going to the district level. This has always been an objective of the reforms, and was expected to have an impact on efficiency through the general recognition that services and interventions at the primary level are in general more cost-effective in meeting the major burden of disease (World Bank 1993; World Bank 1994; MOH 1997).

To the extent that a reduction in the share of government funding going to hospitals and administration can be viewed as an increase in efficiency, the Zambia experience has been quite remarkable in international terms. It is important to distinguish between policy intent, as measured by the budget figures, and actual implementation, using expenditure (as outlined above). Gaps in data availability for expenditure means that there is limited presentation of actual policy impact, as the emphasis has been on budget.

5.3.3.1 Policy Intent: Authorized Budgets

In 1990 almost 15 percent of the initial approved budget and 23 percent of the final authorized budget were allocated to UTH alone, and roughly 25 percent went to services at the provincial level and below (including provincial medical officer offices and 2LR hospitals). In recent years, however, budget figures have shown a significant shift toward the operational level, as shown in Figure 5.5.

Figure 5.5. Share of MOH Budget Allocated to the Provincial Level, 1990-1999

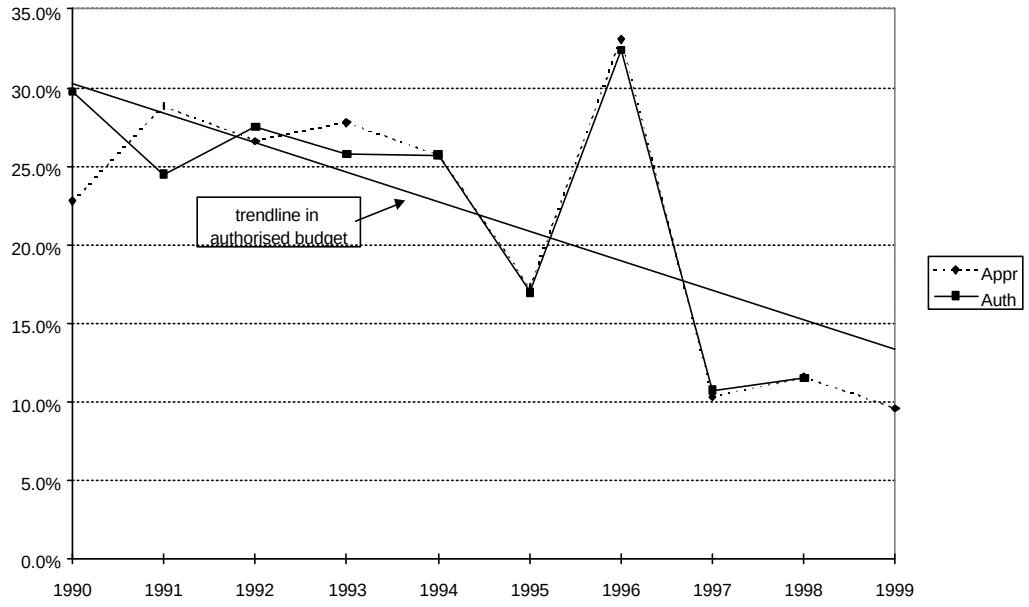


Note: For the period 1990-93, these figures include personnel emoluments and recurrent departmental changes at the provincial level as given in the relevant Yellow Books. For 1994-96, they include districts, RHAs, and 2LR. From 1996, salaries for mission employees paid by the MOH and allowances for students at mission hospital nursing schools are listed separately within the budget and included here. From 1998, costs for the RHAs are excluded as these were included within the CBOH budget, hence the graph underestimates the full extent of the increase to that level.
Source: MOF Yellow Books (1990-99); MOH budget data (1994-99)

This figure shows that there has been a sustained upward movement in both approved and authorized budgets to the provincial and subprovincial level over the period of the study. The linear trend line shows an average annual increase of less than 1 percent of the final authorized budget being allocated to this level between 1990 and 1998. Although not shown, the trend line for the approved budget is similarly upward sloping, but it has a more gradual increase, implying that adjustments to the original budget have been in favor of the lower levels.

This shift has been accompanied by a corresponding fall in the share of the total budget going to 3LR hospitals, with the exception of 1998. The clear policy intention to shift funding away from major hospitals is shown in Figure 5.6, with the linear trend line again reflecting the final authorized budget and showing an average fall of nearly 1.9 percent per annum between 1990 and 1998.

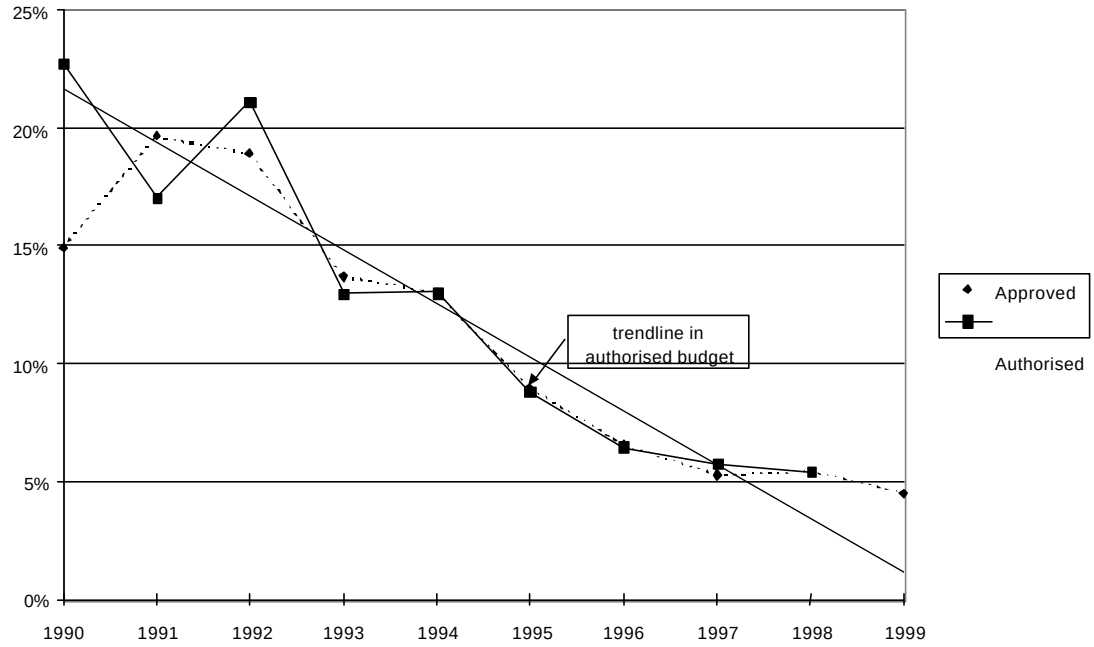
Figure 5.6. Share of MOH Budget Allocated to 3LR Hospitals, 1990-1999



Notes: Hospital budgets include personal emoluments.
Source: MOF Yellow Books (1990-99); MOH budget data (1994-99).

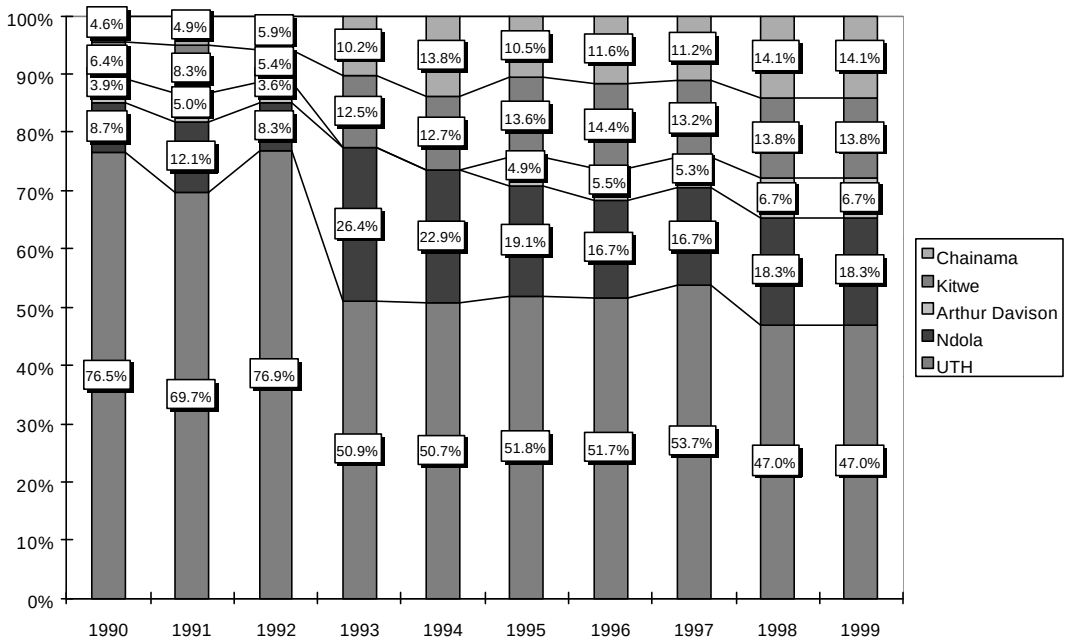
It is worth pointing out that within this overall reduction in the share of the ministry budget allocated to 3LR hospitals, UTH has seen the most dramatic decline. Figure 5.7 shows that the trend over the past 10 years has been a fall of almost 2.3 percent per year.

Figure 5.7. Share of MOH Budget Allocated to UTH, 1990-1999



This can be demonstrated in a different manner through presentation of the relative shares of individual 3LR hospitals over the period under study. Figure 5.8 shows the proportion of funding going to this level by facility. To the extent that the referral hospitals based in Lusaka and the Copperbelt serve the south and north of the country, respectively, the reduction in the share of funding at UTH may thus be seen as a move toward a more equitable geographical distribution of 3LR funding. In 1992, 82.8 percent of the budget for central hospitals was concentrated in Lusaka, but in 1993, this fell to 61.1 percent, with the Copperbelt benefiting accordingly. The effect of this change on the geographical distribution of 3LR budgets has already been noted in Figure 5.4.

Figure 5.8. Proportionate Shares of 3LR Hospital Budget, 1990-1999

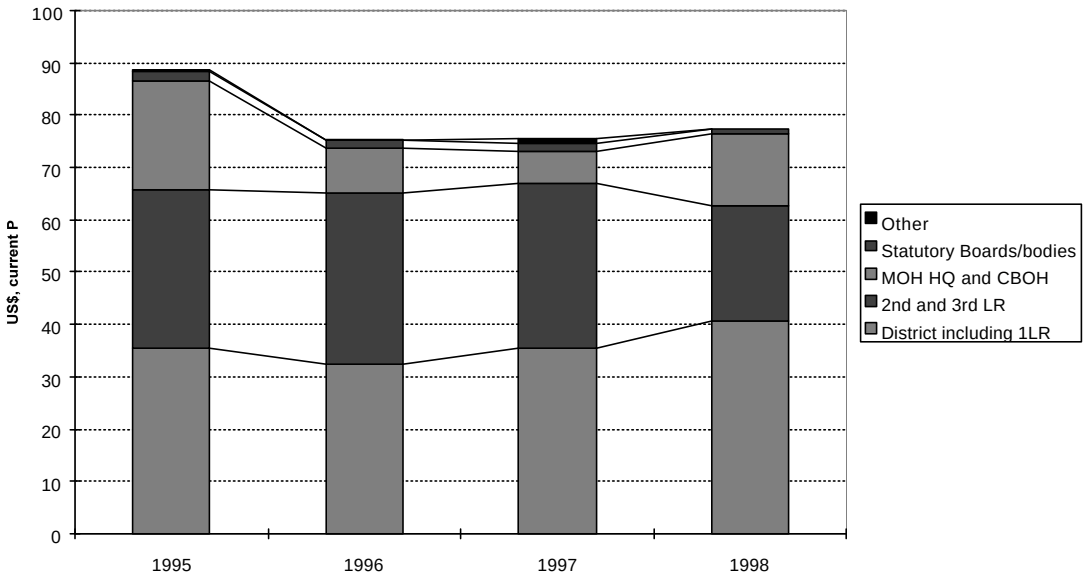


Notes: In 1993 and 1994, Ndola and ADH are combined; from 1993, Chainama includes College of Health Sciences as well as the hospital; data for 1999 reflect approved budget rather than authorized budget.
Source: GRZ Yellow Books 1991-1994, 1998, 1999; Blue Books 1994 –1996

5.3.3.2 Policy in Practice: Actual Expenditures

The extent to which the MOH's commitment to budget reform has been borne out in terms of actual expenditures is less drastic, but still quite impressive. Unfortunately, the data are not complete, but some impressions can be gained from the graphs below. Figure 5.9 shows the final figures for the allocation of MOH expenditures between levels of the system over the last four years.

Figure 5.9. Level of Care Allocation of MOH Recurrent Expenditures, 1995-1998 (current US$)



Notes: Data for 1998 should be interpreted with caution as they represent preliminary rather than final estimates.[53] In addition, MOH assumptions regarding allocations between levels of care are not consistent for each year.
Source: MOH (1998) Strategic Plan; 1998 data from preliminary MOH estimates.

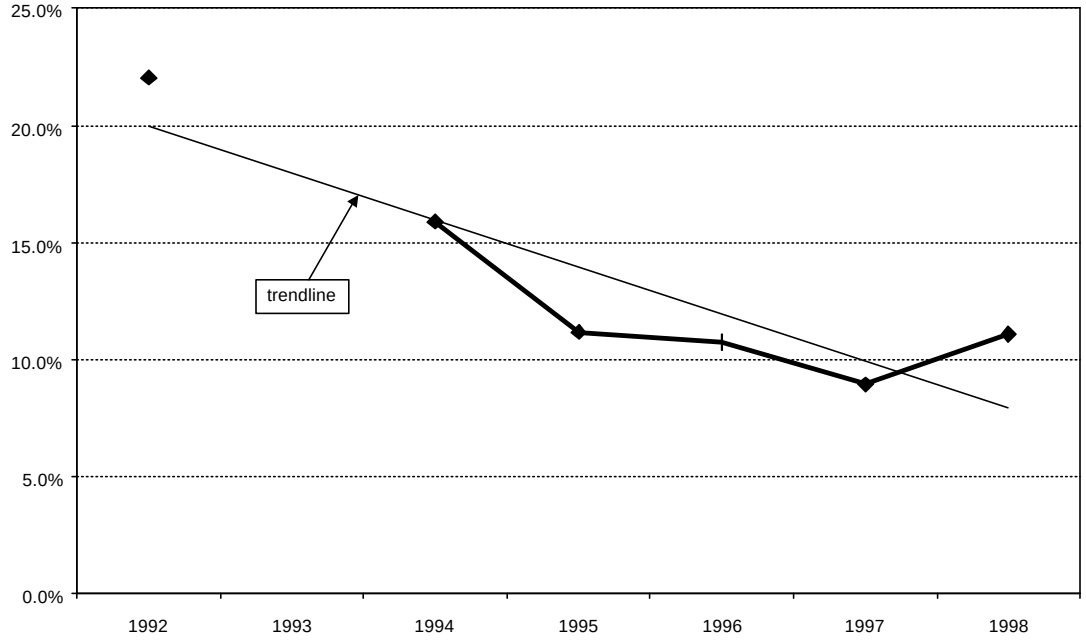
Figure 5.9 demonstrates that MOH has achieved a certain measure of success over the past four years in increasing the absolute level of funding to the district level from $35.5 million in 1995 to $40.7 million in 1998, an increase of nearly 15 percent. As a share of total expenditures, this increase is even more significant, rising from 40 percent to 52 percent (an increase of 30 percent).

At the same time, it shows the severe reduction in funding available to the MOH for health services, down from US$88.7 million in 1995 to US$ 77.4 million in 1998. This has serious implications for the overall sustainability of health services in the absence of additional inflows of resources from either donors or households, and in the context of rising poverty outlined in Section 3.4.2, the latter is unlikely to occur.

As indicated above in the discussion of policy intent, this has been largely at the expense of the referral hospitals. This was particularly the case in 1998 when data indicate a 30 percent fall in expenditures at 2LR and 3LR hospitals, from US$ 31.5 million to US$ 21.8 million. Figure 5.10 shows the trend in expenditures at UTH for those years for which data were obtained.

[53] Although the major exclusions are related to donor funding through the capital budget rather than the recurrent budget (personal communication, MOH and CBOH officials).

Figure 5.10. Trend in Expenditures at UTH, 1992-1998



Source: GRZ Blue Books, various years

This picture is confirmed by a more detailed study of hospital policy in Zambia (Kamwanga et al., 1999), which reports that the steady decline in expenditures has affected the availability of nonpersonnel inputs as the wage and salary bill remains protected. This has serious implications for the quality of health care that can be provided and therefore has a negative impact on efficiency. It has been belatedly recognized only within the past two years that the allocation away from hospitals and toward districts may have been done too quickly, with cost sharing failing to meet the shortfall in government resources.

Resource allocation reform (specifically the devolved budgetary control) has also had an indirect impact on efficiency and thus sustainability, through its reinforcement effect on decentralization. Whereas past attempts to devolve responsibilities have not brought a commensurate increase in resources, the reforms undertaken since 1993 have substantially improved the financial situation at the district level (interview data). Although they have covered only nonsalary, nondrug expenses, any funds directed to that level represent both an absolute improvement in resource availability and enhanced decision-making power at the district by reducing the complex bureaucratic procedures required to solicit funds from the province under the previous system. In addition, by placing more resources in the hands of those closer to the beneficiaries, the health system is better able to respond to local needs. As outlined above, this was expected to increase the sustainability of the sector in the long term.

5.4 Strengthening Health System Sustainability Through Organizational Capacity Development

A further significant impact of the reforms has been the effect on capacity development at different levels of the system. The devolution of decision making, and more particularly financial authority, to districts has been accompanied by systems development (Financial and Administrative

Management System (FAMS) – see Section 3.5.5) and the need to train staff at the district and subdistrict levels in basic management skills. To meet the demands for better management and accountability of funds, CBOH has been conducting an extensive training program for health workers at hospital, district, and health center levels. As a result, contrary to the previous situation where managers were purely health personnel, with little or no training in basic management, accounting departments at districts and hospitals are increasingly being staffed by trained accountants and clerks, and senior District Health Management Team staff have undertaken a residential course in district management. In the words of one district manager, *"Before 1993 [before decentralization], we had no bank account, accounts office; we never kept registers and receipt books. Later on [under decentralization] the issue of accountability came in and receipt books were printed, we started developing systems and things started to change."*

In addition, systems for routine monitoring and audit of accounts by CBOH technical staff have been established as part of the FAMS. Both district health management boards and hospital boards produce annual financial and activity reports as a prerequisite for financial disbursement from CBOH. The boards are also subject to performance audits undertaken by the CBOH, so the flow of information from lower levels is better than before. The development of FAMS has therefore helped to enhance accountability and monitoring of the flow and use of funds in the decentralized system.

As outlined in Figure 3.1, previously districts were involved in drawing up plans that were difficult to implement because the flow of funds came through the provincial medical offices. With decentralization, financial management has moved down to the district level, and this has helped to cut down on the bureaucratic procedures. Interview data from CBOH officials indicate that district and hospital managers are increasingly employing management initiatives in their operations. Hence, the reforms have contributed to organizational capacity by instilling some notable changes in the culture of management of health facilities. Specifically, interviews with directors and staff at some hospitals have indicated that the autonomy given to hospitals has allowed them to employ measures aimed at enhancing internal accountability of resources in the face of considerable budgetary cuts from the MOH. For example, hospitals often engage the services of a professional accounting firm to scrutinize their accounts, and there have been several instances of accounts staff being let go due to financial irregularities.[54]

However, the creation of new structures and devolution of responsibilities to district and hospital boards has not been without its problems. Considerable confusion reigns between the district boards and the DHMTs, and in many cases this has led to serious organizational problems that have made the boards' task of coordinating DHMTs and health centers very difficult. Although there is not sufficient data to attribute this development to either decentralization or cost sharing, there are strong indications that the struggle is about the desire for power ostensibly motivated by the desire to have command over the resources that accompany it. These conflicts are further promulgated by complaints from health workers that members of the DHMTs and district health boards do not allow resources to trickle down to the health centers, i.e., that the blockage that previously existed between province and district has moved one level down the system. Health workers participating in focus group discussions conducted by Daura et al. (1998) and MOH/UNICEF/WHO/WB (1996) complained that district health board officials and DHMT members tended to monopolize workshop attendance. Workers also accused them of withholding information obtained in workshops (which emphasized team work, transparency, participatory approach to problem solving, etc.) from other

[54] At the same time, various observers have argued that there has been an overemphasis on financial matters within the reforms. MOH/UNICEF/WHO/WB. (1996) report one district director as claiming that "*98 per cent of the supervision districts receive is on financial management."*

staff within the district. Accessibility to other resources such as vehicles was another possible cause of reluctance to relinquish power. Furthermore, health workers complained that even accessing fee revenues, which are kept in a district account, is a big struggle because district officials are allegedly reluctant to release funds to health center staff. Studies that have evaluated the performance of cost-sharing schemes (e.g., Daura et al., 1998) also confirm that the local decision making and general activities at the district level have been negatively affected by the struggles that have emerged between the different local structures (namely the district health boards, the DHMTs, and health workers) created under decentralization. As mentioned, these differences are a result of the resources that benefit only certain categories of these structures. Consequently, local decision making is often characterized by political differences between the different structures that have been created.

Decentralization of decision making has also generated some power struggles between top officials in the MOH and the CBOH, and this has turned decision making on certain matters into political battles. MOH/UNICEF/WHO/WB (1996a,b), for instance, reported that the MOH has not relinquished the appointment of top positions such as directorship to hospital boards. This has been confirmed in interviews with senior members of the CBOH and MOH. It is conceivable that the demands of the new decentralized system were beyond the capacity of the existing institutional capacity to handle effectively, particularly early on.

Another accomplishment of the reform process is with regard to mobilization and coordination of donor funds. As outlined in Box 4.1 and Section 5.3.2, the MOH, working together with the donor community, has successfully implemented a 'basket funding system' such that donor funding for district health services are pooled into a common basket fund prior to allocation using the same formula as GRZ funding. The success of the basket system has led to the decision to extend it to other levels of the health system and ultimately to move towards a sector-wide approach to external support, whereby all partners would contribute to a central level "basket," which would then be allocated according to the priorities outlined in the Strategic Plan (agreed upon in the biannual MOH/CBOH/partners consultative meetings) (MOH 1998; Lake and Musumali 1999). The existing District Basket Steering Committee would then become a broader Health Sector Support Steering Committee.

5.5 Summary and Conclusions

In summary, the impact of the reforms of focus has varied. There is evidence of success as well as outstanding problems with respect to both cost sharing and resource allocation reforms. Table 5.7 provides a summary of these. Notable successes include the initial equity gains due to use of a resource allocation formula and the protection of some groups from payment through application of the exemptions policy. Efficiency gains resulting from the deliberate shift of resources from the tertiary level to the more cost-effective primary health care level represent arguably the greatest positive impact on sustainability.

Table 5.7. Summary of Impact of Financing Reforms of Focus

Impact on Equity		
	Successes	**Problems**
Utilization	Limited evidence of utilization rising over time, particularly where payment is tied to drugs dispensed	High proportion of total population does not seek care when ill Drop in overall utilization in almost all public facilities and by all demographic categories Both inpatient and outpatient service utilization dropped
Pattern of access	Demographic-based exemptions working well to foster categorical equity (particularly for children)	Health services remain less accessible to poorer households, despite exemption policy
Pattern of resource allocation	Bold shift from tertiary to PHC level. Introduction of objective allocation criteria for district funding Basket funding system has improved donor fund coordination and allocation	Lack of, and inadequate monitoring against, defined geographical equity targets Transparency not yet firmly established in MOH with respect to intra-sectoral allocation decisions in times of shortfall from MOFED
Impact on Sustainability		
	Successes	**Failures**
Financial sustainability & quality of care	Revenue collected has sometimes been used at facility level to improve the working environment and quality of services Better staff attitudes toward patients due to bonus from fee revenues (and, in some cases, reduced attendances)	Cost-sharing revenues remain inadequate in the face of the total funding gap Continuing drug shortages represent major quality shortcoming and affect user confidence/acceptability in the reforms more generally
Organizational capacity	Decision making has been brought down to lower levels hence curtailing the previous bureaucracy Some improvements in accounting and financial management at hospital and district level Information flow has been enhanced, through FAMS Increased accounting skills Some visible changes in the culture of management at health institutions, e.g., local initiatives to raise revenues, firing of staff caught stealing	Districts especially in rural areas still lack adequate capacity at local level in effective planning and management Failure to harmonize relations between various structures, leading to disputes in decision making at lower levels Reforms encroaching on weak institutional capacity hence leading to misunderstandings, disruptions, and weakened accountability
Acceptability of the reforms	Increased consumer consciousness of cost Increased consumer concern for quality	Highly visible drug shortages have restricted public confidence in the reforms and generated some resentment to fees, which are seen as double taxation

The entire health sector has undergone a major restructuring of the institutions that organize, manage, and provide health care in the country. At a macro level, the overall organizational changes that have taken place under decentralization have led to the creation of the CBOH and a streamlined MOH charged with overseeing the operation of the entire health care delivery system, in particular, articulating and implementing policies. Given the view of the MOH prior to 1991 as having no clearly articulated vision, with operations marred by weak institutional capacity and informational constraints, it can be argued that as a result of the reforms the sector is better positioned to take effective control of its operations and long-term vision. Of more direct importance to the reforms of focus is the decentralization of financial authority such that funds are now disbursed directly to the districts through an objective allocation mechanism, and districts have the right to spend the money according to their priorities and activities. The sustainability gains resulting from these policies largely reflect the contribution that such decentralized budget control has made in improving district management capacity.

6. Design Factors Influencing Success

As seen in Section 5, the reforms of focus have had varying success in terms of achieving both their own stated objectives and those of equity and sustainability. Various factors explain this success, and this section considers the influence of technical design. Findings are presented in four parts. The first part discusses specific features of the different cost-sharing reforms and their influence on the equity and sustainability impacts described in the previous section. The second part presents the effect of design features of the resource allocation reforms. The third part assesses linkages between the design of financing reforms and the specific organizational reforms of decentralization. Lastly, the section analyzes the linkages between financing policy and other elements of the reform package.

6.1 Technical Design Features: Cost Sharing

Various design features of the cost-sharing reforms of focus have influenced their impact on equity and sustainability, as summarized in Table 6.1. These are discussed in more detail below.

Table 6.1. Design Features and Impacts

Feature	Intended Objective	Impact
Retention of fees/local management of fees	Improve quality of care, particularly drug procurement Strengthen local skills and ensure responsiveness of health system	Improved quality at facility level Improved skills Community participation
Bonus to staff; a proportion of collected fees	Improved quality through effect on staff morale	Inefficient provider behavior, fees collected even from those deserving exemption
Prepayment cheaper than user fees	Ensure access for majority Enhance resource base Provide stable source of revenues	Reduced revenues at hospital level Inefficient consumer behavior; over-utilization of health system: moral hazard? Adverse selection
Graduated fee scale by level of health system	Encourage appropriate use of health system	Increased utilization of lower levels
Bypass fee for nonreferred cases	Encourage appropriate use of health system	Increased utilization of lower levels
Fees linked to services	Encourage utilization	Willingness to pay for quality care-drugs: e.g.,Kitwe
Prepayment cheaper than user fees	Ensure access for majority Enhance resource base Provide stable source of revenues	Reduced revenues at hospital level Prepayment cheaper per month Prepayment too expensive per year Inefficient consumer behavior -- over-utilization of health system: moral hazard Adverse selection
Exemptions	Ensure access	Categorical exemptions protect young and elderly, but less protection for lower income
All preventive services free of fees	Ensure access	Practice varied with some districts charging: access curtailed

6.1.1 Fee and Prepayment Premia Levels

Health care is subject to the laws of demand, which basically state that demand will fall as prices rise. While not entering into a detailed debate regarding what might constitute "demand" in the context of the health sector, it is clear that pricing aspects of the cost-sharing reforms implemented in Zambia have influenced their impact on access to health care.[55] To some extent, this has been due to the potential conflict between the two main objectives of cost sharing referred to in policy documents and in interview data. While initial policy stressed the need to raise additional revenues for the health sector, the 1993 circular permitting the introduction of user charges implicitly recognized the objective of "partnership" through its specification that charges should be:

[55] Access and utilization are considered here to be one of four measures of equity (see 2.4).

- Determined in consultation with hospital advisory committees and community leaders
- Set at levels "which the vast majority of the members of the community can afford" (MOH 1993).

However, there is scant evidence in subsequent evaluations that these conditions were adhered to by implementors or monitored by the central Ministry of Health, and the belief that substantial revenues might be generated from cost sharing may have dominated decisions regarding fee levels.[56] The impact on utilization presented in Tables 5.2 and 5.3 suggests that fee levels may have been set too high and thus deterred people from seeking care in the public sector. For example, the study by Kahenya and Lake (1994) found that utilization rates fell much less for services subject to lower fees.

As mentioned in Section 4.6.2, Michael Sata, the Minister of Health in 1994, introduced the cash prepayment scheme primarily on the grounds that user fees had become too expensive. At the time of its introduction at the University Teaching Hospital (UTH), the initial premium was set at K500 per month for an adult and K50 for a child between 5 and 16, compared with user fees at the hospital, which were around K4000 per adult outpatient visit (Health Care Financing Working Group minutes). This rate subsequently rose to K800 for an adult and K300 for a child at UTH in early 1995, but remained substantially lower than user fees both at the hospital and in Lusaka clinics, which were K2,500 and K1,000 for adults and children, respectively. The introduction of an alternative mode of cost sharing, which effectively lowered the price of seeking care in public health facilities, appears to have had a positive impact on accessibility. Health workers in Lusaka, for example, directly linked an increase in attendance to the introduction of the scheme, as was cited in Table 5.3 (Atkinson et al., 1996).

However, the extent to which this represents a genuine increase in access for necessary care is questionable. The design of the prepayment scheme allows members an unlimited number of visits to facilities during the period of coverage, and there is evidence that this has encouraged inefficient consumer behavior, whereby members frequent the health facilities collecting drugs for future use in times of drug outages at facilities (Atkinson et al., 1996; Daura et al., 1998).

One senior MOH official, speaking of the K800 prepayment premium in Lusaka, believed that a flat level premium was regressive because the economic status of people in the locality was not the same. In his view, because some community members were businessmen or entrepreneurs and therefore wealthier than others, a more equitable fee structure would have been graduated by level of income of the individuals so that access would not be curtailed nor would available resources be left unmobilized. However, the administrative complexity of such a design would make it unfeasible, particularly given the limited capacity within the sector to manage it.

The MOH chose to handle the issue of reduced access by articulating its exemption policy. Exemptions from charges effectively set a zero price for certain services and population groups. The objective of such a policy may be to promote the uptake of certain health services, such as preventive and promotive interventions and those with a public health impact, and/or to ensure that financial barriers to access are removed for those identified as unable to pay. The successful implementation of an effective exemption policy should therefore mitigate the worst effects of cost sharing on utilization of essential health services.

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[56] For example, as one interviewee stated with reference to a former Minister: *"...I was very wary of going straight into nationwide user fee policy. I never really accepted that as our policy. But XXX was excited, when he looked at the fact that by charging all this money, everyone's spending tons and tons of money… you could actually run everything on user fees…"*

Exemptions on grounds of age appear to have been the most successful, as discussed in Section 5.[57] This is likely to be due to the relative ease of their application. Clarification of the policy of providing certain services free in 1995 also appears to have been broadly successful, although it can be argued that the two-year delay in specifying these categories hampered access. The inclusion of civil servants as an exempt category in the 1993 circular, due to government "general orders" outlining conditions of service, has however had a negative equity impact as this group cannot claim to be among the poorest in the country. Coverage of this group through the Public Servants Medical Aid Scheme (outlined briefly in Section 4.6) is expected to overcome this anachronism.

The greatest failing has perhaps been seen in the design of the exemption policy with respect to those unable to pay. Initially, the fault lay not so much in any particular design feature as in the failure to design a specific modality for such exemptions, with MOH leaving the responsibility for this group to the Ministry of Community Development and Social Services (MOH 1993). However, since the initiation of work on the Health Care Costs Scheme in 1995, research findings have generally shown that efforts to promote equity through application of an exemption policy have had mixed results. Effective modalities for identification of the poor have not been worked out, nor has funding to the HCCS been adequate to meet the needs of the vulnerable.[58]

In addition, the poor often have had to meet other costs when accessing medical care. Research shows that 50 percent of the people who claimed that medical fees were too expensive were in fact referring to the transportation cost as being the most exorbitant (interview data; Hjortsberg and Mwikisa 1999; Diop et al., 1998). Thus providing free care at the point of delivery does not in itself enhance equity since accessing care still involves some cost for the poor members of society.

6.1.2 Type and Scope of Fees/Premia

Generally, the heterogeneity of the Zambian economy and society has made it difficult to devise a single cost-sharing mechanism that can be applied nationwide (Kalyalya et al., 1998; Kutzin 1996). Zambia has traditionally had a largely dual economy (mining and agriculture), which has resulted in diversity in economic development among the different regions. The highly urbanized and industrialized areas of the Copperbelt, together with Lusaka and the line of rail that joins the two provinces, tend to have wealthier districts with populations that are formally employed and earn regular wages. Cash payment schemes can therefore be implemented relatively easily in these regions. The largely rural hinterland offers largely agricultural employment opportunities to its population, often at subsistence level, and therefore cash payments are not always appropriate; hence the appeal of such mechanisms as the Mwase Mphangwe in-kind prepayment scheme. The early policymakers recognized this fact, as evidenced by comments from a former Minister of Health: "Where we knew we had a big problem was the rural areas. How do you get our people in the rural areas to make a contribution to health?" The evolution of policy in a way that has enabled both fees and prepayment to be introduced is therefore welcomed.

The scope of what cost-sharing measures actually cover also can be criticized, although it is not possible to generalize for the country as a whole because of the diverse nature of implementation. Despite *National Health Policies and Strategies* (*NHPS*) referring to "a flat registration fee for outpatient (OPD) and in-patient care," in some places a relatively complex fee structure was initially

[57] Table 5.2 appears to show a different picture with respect to the under-five age group.

[58] This was due in part to MOH's decision to request $1 per month from the scheme for people covered under HCCS, in order to recover the $12 per year that the package of care was estimated to cost. This compares with a cash prepayment premium of approximately $4 per year for those paying out of pocket.

introduced, with a number of different payments required once care was sought (MOH 1992: 34). In Lusaka, for example, "the user paid for each stage of the consultation. Thus there was a registration fee, a fee for any further tests needed, charges for drugs, and then if the client was referred, often they found they had to pay again at the hospital" (Atkinson et al., 1996). This was felt to be both complicated and expensive.

The decision by Minister Sata to proscribe charging for drugs in early 1994,[59] while simplifying the charging structure at many health facilities, severed the link between payment and treatment in the eyes of the patient. For many patients, the consultation element of a visit to the clinic is less important than the receipt of drugs. There appears to have been a subsequent vicious circle whereby reduced attendances, arguably due to the fact that in some places fees for registration or consultation were raised as a result (Lake 1994a), had a negative effect on revenues, thus limiting the ability of facilities and districts to supplement their drug stocks. Although drug shortages are only partially attributable to reduced cost-sharing revenues,[60] several studies on the implications of user fees have quoted focus groups and interview respondents in regard to this particular feature of charging (Booth et al., 1995; Atkinson et al., 1996; Kalyalya et al., 1998).

In addition to the relatively low level at which prepayment premia were set, a major difference in the design of the scheme that appealed to the public was that it was a one-off payment covering all aspects of consultation and treatment. As noted in a study of Lusaka urban health care, which sought the views of users about different aspects of the reform impact, "the introduction of the [prepayment] scheme is seen as positive relative to the user fees. Users like this because they feel they can get the full treatment with the card, whereas with fees you have to pay for each part and may not afford it all." (Atkinson et al., 1996: 20).

6.1.3 Revenue Generation

To contribute to financial sustainability—one of the original objectives of reform—cost-sharing measures obviously need to generate revenues in excess of their costs. Although administrative costs have been kept low by using existing staff to perform cashier functions, at least at the health center level, this is again an area where the dual objectives of resource mobilization and partnership potentially conflict. As already noted in Section 6.1.1, the introduction of fees is believed to have directly contributed to reduced attendances, at least initially. Obviously revenues are not generated when people choose to stay away from health facilities or seek care elsewhere, and it may therefore be the case that lower fee levels might have resulted in increased revenue through a lower drop-off in utilization.[61] Unfortunately, the information systems in place at the time prepayment was introduced were not sufficiently sensitive to allow calculation of revenues generated by different cost-sharing mechanisms.

When prepayment was first allowed at the district level, the design of the scheme allowed purchase of a card at any facility for use at another. The inclusion of the hospitals at this time meant that often revenues were generated at the health center level, while members chose to seek care at the hospitals. This was subsequently amended first by the onward transmission of 40 percent of

[59] Cf the statement in *NHPS* that *"charges for drugs shall be instituted at all levels of health institutions except Rural Health Centres and Health Centres in slum areas."* (MOH 1992a: 35)
[60] And information systems at the time do not permit direct causation to be attributed.
[61] To prove this would require calculation of the elasticity of demand for different services by different population groups. Evidence on this subject is mixed (see Sauerborn et al., 1994), and other factors such as the quality of care and other costs of seeking care are also influential.

prepayment revenues to the hospitals, and then by restricting the scheme to districts and closing the third-level referral hospital outpatient departments.

Study findings have also indicated that, as a result of the weak identification marks on prepayment membership cards, members could share the card with nonmembers. As a result, the number of members who were officially paid up was lower than the number actually benefiting from the scheme, thereby reducing the potential revenues (Atkinson et al., 1996; Daura et al., 1998).

At the hospital level, the issue of raising revenues through cost sharing has been inextricably linked with the equity and efficiency objectives of reducing government expenditure to prioritize more cost-effective district health services. There is evidence to suggest that hospitals were having some success in terms of generating resources, with the executive director of UTH reporting to a meeting of the HCFWG in early 1994 that cost-sharing revenues were K14-15m per week prior to the introduction of prepayment (about US$20,000 to $22,000). However, the introduction of prepayment at the third-level referral hospitals at a significantly lower rate than fees had a predictably negative effect on revenue generation, with revenue at UTH falling to K11-12m (US$16,000 to $17,000) per week afterwards (HCFWG 1994).

6.1.4 Use of Revenues

The fact that revenues have been retained within the health sector is undoubtedly a positive feature of the cost-sharing policy. As outlined in Section 4, specific guidelines on the use of revenues have been issued at various points in time, the earliest of which referred to decisions regarding expenditures to be made in consultation with the Hospital Advisory Committee.[62] *NHPS* originally stated that, *"Health care quality must be improved as part of a process which utilises better management to reduce costs and to enhance efficiency and effectiveness before charging consumers"* (MOH 1992: 33). However, the decision to allow charging at lower levels of the system was explicitly intended to lead to improvements in quality, as recalled by the minister in charge of issuing the circular: *"We said that 90 percent of the money collected…was ploughed back into patient care; it has to go to patient related activities."* This included the purchase of drugs to supplement those coming through the central distribution system (Choongo and Milimo 1995).

The other 10 percent of fee revenues was intended to improve quality of care by providing a small salary supplement, referred to as a "bonus" to health staff. On the one hand, this bonus has been viewed as a good incentive for staff to collect revenues; however, it has also been argued that this feature has curtailed access because health center staff collected fees even from those who should be exempted, for the obvious reason that the staff were getting some direct financial benefit (interview data; Daura et al., 1998).

The importance of drugs as an indicator of quality, and the known linkage between perceived quality of care and utilization, mean that the success of revenue collection in enhancing access to health care is closely linked with drug availability.

A further problem with the prepayment scheme arises from its optional nature, with access to the benefit package depending on sickness. This has led to a loss in interest in the scheme, partly because those who did not fall sick during the period of coverage lost their benefits. Consequently, those who tend to be sickly are more likely to prefer this system since they demand more health services, and

[62] Reflecting the fact that the initial circular talked of introducing fees at the hospital level only (see 4.6.1).

there has been a high dropout rate among those who did not use the scheme (Daura et al., 1998). Such adverse selection implies that the scheme's financial sustainability is highly questionable. One prominent policy maker, while criticizing the optional feature, contended that the prepayment scheme would have had a greater measure of success had it been made compulsory (interview data). Although no studies on the issue of adverse selection are available, by inference, it can be deduced from the high dropout rates of healthy individuals that only those who are sickly have an interest in maintaining membership in the scheme.

6.1.4.1 Efficiency

Certain design features of the cost-sharing policy were concerned with controlling the use of the health system and the need to promote efficiency. To achieve this objective, user fees were to be differentiated between the different levels of the health system, with a bypass fee being charged against those presenting at the hospital without a referral letter from the lower levels of the health system (MOH 1992a: 35). To encourage the use of primary health services, higher fees were to be charged for the same service at higher levels of the system.

The lack of coordination in fee design among the different levels of the Zambian health system, however, created a situation whereby, in some cases, it was cheaper to access higher levels of the system (Kahenya and Lake 1994). Similarly, although the decision to begin charging initially at hospital level was in part to encourage the use of lower levels of the system (interview data), the subsequent introduction of relatively low-cost prepayment at that level reversed the positive effects of decongestion. In addition, benefit packages that worked contrary to the stated objectives of encouraging the use of lower level facilities were developed and implemented, resulting in further overcrowding and over utilization of hospital facilities (HCFWG minutes).

A graduated premium structure was belatedly introduced in the prepayment scheme following its extension to the three districts of Ndola, Kitwe, and Lusaka, with marginally higher premia payable at the hospitals. Ultimately, however, third-level hospital direct outpatient clinics were closed when Kalumba became minister in 1996. This may possibly have been due to the recognition that the differential between fees and prepayment premia at hospital level was so great that it would inevitably lead to inefficient use of the referral system.

6.1.4.2 Access

Although intended by its architect to provide a cheaper alternative to the user fees (Sata 1994), implementation of the less expensive prepayment scheme at the hospital level went against the objectives of encouraging first contact at lower levels (interview data). In addition to eliminating first contact at lower levels, the implementation of prepayment at hospitals where user fees had been in place directly impacted the revenue collections by reducing the amount of money that could be collected from the community. As a result, hospital directors at UTH, Kitwe, and Ndola reported substantial decreases in revenue collection.

Other features in this category included retention and local management of fees and bonuses to staff from the collected fees. These features had mixed impacts. The retention of fees had some limited success in achieving the objectives of improving quality and strengthening local skills and community participation.

6.1.4.3 Financial Sustainability

Retention of fees at the point of collection is another key feature of the financing policy. With this policy, facilities were to improve the quality of care by procuring additional drugs and other medical supplies when need arose.[63] However, general practice in Zambia has seen the reverse. Initially, fees were generally not retained at point of collection, nor were the fees used to purchase additional drugs. Initial policy reinforced the misappropriation of funds in the Lusaka Urban District Council in 1994, stipulated that collected fees be retired at the district level for security/accounting purposes and that health care facilities would thereafter access their money at any given time on condition that an approved program of activities is presented. Only one example was foundwhere collected revenues have been utilized to procure drugs and fees linked to the provision of drugs. Substantial increases in utilization rates were noted in Kitwe, the only district to practice the linking of fees to drug availability (HCFWG). Fees were collected from consumers only upon the provision of drugs at the end of the visit. This practice is said to have created such an overwhelming positive response in patients that Kitwe thus provides a good example of why fees should be linked to the provision of drugs as a way of ensuring successful implementation of fee policy.

6.1.5 Linkages between Cost-sharing Reforms

Linkages between cost-sharing reforms are evident among the various mechanisms for mobilizing resources; the most notable of these has been the link between user fees and the prepayment scheme. Various studies have shown that the prepayment scheme, although designed as a cheaper alternative to user fees, has tended to be very expensive when considered on a yearly basis, particularly for large families who have to maintain the individual schemes by paying monthly installments (Daura et al., 1998). The consequence has been that families have devised ways of making it less costly by either buying one card, which they then swap so that any member of the family needing care uses the same card, or by re-registering as new members every time sickness occurs in the family (Daura, et al., 1998). That prepayment is cheaper cannot be denied, considering it costs only K800 for one month of coverage with an unlimited number of visits; however, both policy and practice require that yearly membership be maintained by individuals so that the scheme provides a reliable and therefore sustainable source of revenue for health facilities.

The links between user fees and insurance have also been observed. The apparent limited understanding of the benefits of risk pooling has undermined the acceptance of the prepayment scheme as a tool for risk sharing and protection against out-of pocket payments in the event of sickness (Daura et al., 1998). Moreover, pooling resources would increase the sustainability of the health system. Given the opportunity to choose between prepayment insurance and user fees, households would most likely opt to make an out-of-pocket payment where health care would immediately be rendered than to pay in advance and not receive benefits for a long time. Consumers regard making prepayments without accessing care as a waste of money (Daura et al., 1998). This way of thinking has impacted directly on the prepayment scheme whose membership record continues to weaken.

In addition to the poor design of the fee structure, weak supporting systems are noted to have limited achieving the goal of efficiency. UTH, a tertiary hospital, for instance, provided a standard package that included a medical doctor at consultation with drugs being provided at the end of a visit. In contrast, health centers at the time did not employ medical doctors, relying instead on clinical

[63] Referred to initially in the second MOH 1993 circular on fees (see footnote 39)

officers to diagnose disease (Kahenya and Lake 1994). The perceived quality differential between access to a doctor and to a clinical officer has undermined the population's willingness to use health center facilities. In particular, the lack of doctors, persistent drug shortages, and poor staff attitudes at the health center level have all been cited as major reasons for lower level facilities being under used (Kahenya and Lake 1994; Daura et al., 1998).

6.2 Technical Design Features: Resource Allocation

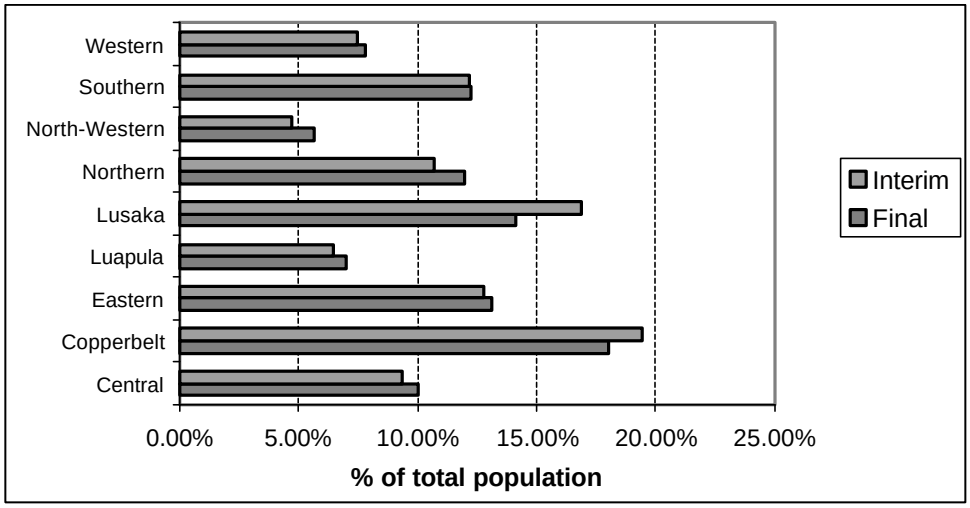
Zambia's resource allocation policy has had a noticeable impact on the objectives of equity and sustainability as defined in sections 5.3.2 and 5.3.3. However, it should be reiterated that the early designs of the capitation-based formula in 1993 and 1994 were seen as a relatively crude first step towards a more sophisticated mechanism for the geographical allocation of funds (interview data). A number of features of these early formula designs have mitigated this impact, and these are discussed below.

6.2.1 Population Data

In any setting, but particularly in a resource-poor country such as Zambia, the need for transparent and equitable resource allocation is critical in order to ensure a fair and efficient use of available scarce resources. Despite the limitations of unavailable or inaccurate data, the need to relate geographical allocations to the population served is broadly agreed (Bevan 1991; Bennett 1993; Doherty and van den Heever 1996), and therefore the availability of accurate population estimates is critical.

In the first years of the formula, district populations were based on projections from the interim 1990 census data (CSO 1993), using the inter-censal growth rate for each district. These were calculated within the MOH. In later years, a variety of different population figures have been used, reflecting the different rates used within government. Examples of these are the CSO projections based on final census data, figures used by UNICEF during the National Immunisation Day campaigns, and in some cases districts' own estimates. Comparison of provincial population projections based on the interim and final census estimates are shown in Figure 6.1 to illustrate the importance of accurate data. The percentage difference for each province is given in Table 6.2 below.

Figure 6.1. Effect of Data Source on Provincial Population Share, 1994



Source: CSO (1992); CSO 1995

Table 6.2. Percentages Difference in Provincial Populations, Interim and Final Census Data

Province	% Difference
Central	7.7%
Copperbelt	-7.3%
Eastern	2.4%
Luapula	8.7%
Lusaka	-16.5%
Northern	11.4%
North-Western	18.8%
Southern	1.0%
Western	5.1%

As Table 6.2 indicates, the population in the two urban provinces, Copperbelt and Lusaka, was originally overestimated. In the case of Lusaka, this was significant at over 16 percent, and it was due entirely to an overestimation of the Lusaka district population as the two rural districts were underestimated (CSO 1995). At the same time, the population of North-Western province—one of the most remote, rural parts of Zambia—was underestimated by almost 20 percent. The use of interim population data—the only data available at the time—inadvertently resulted in an urban bias in resource allocation and thus a negative impact on one of the stated objectives of broad reform policy. This example clearly demonstrates the need to update information sources as they become available when using such a formula.

It is likely that the use of the other sources of population data mentioned above (i.e., MOH internal projections) has also had an impact on the final distribution of financial resources, although in the absence of data this cannot be shown. Where sources are unofficial, such as a district's own estimates, the use of such information subjects planners to a possible claim of favoritism. The use of multiple sources of population data reduces the transparency and objectivity of the formula and

suggests a return to *ad hoc* decision making and the "rewarding" of those who shout loudest (MOH 1996, interview data).

6.2.2 Infrastructure Adjustment

Although it was decided to allocate funds predominantly on a per capita basis, the introduction of the formula took place at the same time as the introduction of guidelines on the proportional allocation of funds *within* districts. These were given to the districts in the form of ceilings for planning and budgeting purposes, and the percentages are shown in Table 6.3.

Table 6.3. 1994 Ceilings for Intra-district Allocations

	Districts without Hospital Board (%)	Districts with Hospital Board (%)
District administration	5	5
First-level referral services	40	33
Primary health care	55	62

Source: MOH (1994) circular from PS [64]

Although there is a substantial variation in the number of hospital beds between districts, even for first-level referral facilities, it was decided to maintain a minimum level of funding for all existing "approved" beds[65] while further thought was given to a policy of rationalization. The Churches Medical Association of Zambia had traditionally allocated its funds to facilities on the basis of a given amount per bed, based on calculations by mission hospital accountants. The ministry adopted this figure as the minimum to be allocated per public sector bed, with 50 percent of that amount being allocated for mission facilities. The decision to fund missions at a lower level than public facilities was made on the grounds that government had a duty to subsidize rather than fully fund mission provision, and therefore the remaining 50 percent should come from external (mission) sources. Where the relevant percentage was insufficient to meet the proposed allocation to first-level referral facilities, additional funds were found from the monies deducted from those districts whose higher level facilities were funded independently.

The decision to adjust the proposed district grants to take account of existing infrastructure had a significant effect on final per capita allocations between districts, as shown in Table 6.4, and influenced the final weight given to a district by as much as two-thirds.

[64] This was amended for 1995 to show a range of values as the total of 100 percent did not allow sufficient flexibility for districts to reduce funding to a particular area.
[65] Mission facilities often have a higher number of beds than those officially "approved", and this is a frequent source of complaint in relation to funding.

Table 6.4. Impact on District Weights of Infrastructure Adjustment, 1994

Province	District	Initial Weight	Final Weight	% Difference
Eastern	Katete	1.00	1.05	5%
Lusaka	Luangwa	1.20	1.85	54%
North-Western	Kabompo	1.20	1.49	24%
	Kasempa	1.20	1.55	29%
	Mwinilunga	1.20	1.44	20%
	Zambezi	1.20	1.97	64%
Southern	Mazabuka	1.00	1.21	21%
	Siavonga	1.00	1.04	4%
Western	Lukulu	1.20	1.23	3%
	Sesheke	1.20	1.93	61%

Source: MOH 1994 budget figures

In all districts other than Lukulu, this was a direct result of the presence of mission facilities, whether large single institutions (as in Luangwa and Katete), or one or more mission hospitals in addition to a government facility (as in Sesheke and Zambezi).[66] The move in 1998 towards population-based budgets for first-level referral care, rather than infrastructure adjustments, therefore represents a positive step towards the equitable allocation of financial resources.

6.2.3 Consideration and Definition of "Need"

Although not made explicit in any policy documents, the equity principle, which has been pursued through the introduction of the resource allocation, has been one of promoting "equal distribution of financial resources for equal need." The concept of "need" is complex and has given rise to a broad debate regarding its measurement in countries where such a formula has been adopted (e.g., Culyer 1995; Newbold et al., 1998). Although population is the core of the Zambian allocation formula, there has always been an explicit recognition that the absolute size of the population is only one element of "need" and that other criteria should be included.

6.2.3.1 Need related to demographic profile

Although other countries have typically considered the age and sex distribution of the population to be important,[67] no consideration has been given to this issue to date in Zambia, despite the fact that children under five and women of reproductive age account for a substantial proportion of health service use and that conditions among these particular groups contribute heavily to the disease burden (World Bank 1993; World Bank 1994). However, this is under consideration for the future (personal communication, CBOH official).

[66] It should be noted, however, that given the substantial underestimation of the North-Western Province population based on the interim census data (see Table 6.3), the infrastructure adjustment might not have needed to be so large had more accurate data been available.
[67] For example, see DHSS 1976; Eyles and Birch 1993.

6.2.3.2 Need related to health indicators

International debate concerning the use of health indicators has typically focused on standardized mortality ratios. The lack of appropriate data in Zambia, however, has led to the use of more simple indicators. Although there has been concern that inclusion of health indicators as a factor in resource allocation could create perverse incentives (Cederlöf 1996; interview data), it was decided in 1994 to include "cholera or dysentery proneness." This was intended more to encourage those districts suffering frequent outbreaks of these diseases to take appropriate preventive action (and thus avoid the common situation of resources being "thrown" at them by government and donors alike at the time of an outbreak) than to encompass health status more generally.

6.2.4 Limited Scope of the Formula

One factor limiting the potential impact of the district formula, at least in the early years of its implementation, was the fact that it accounted for a relatively small proportion of the total budget of the districts. This is due to the fact that funding neither for drugs nor for the salaries of the majority of health service personnel are included. One recent estimate suggests that the proportion of funding that the grant represents is in the range of 40 percent.[68] However, inconsistencies in the figures between data sources mean that such estimates must be made cautiously.

Drugs are purchased through central procurement, previously undertaken by the MOH but increasingly now the responsibility of the CBOH. According to the 1998 strategic plan, 60 percent of the total budget for drugs and medical supplies was to be allocated to the district level, but it is unclear whether this has happened in practice. As part of the early Financial and Administrative Management System work, there were initial attempts to ensure a population-based distribution of this central budget for drugs, but it is also unclear to what extent this has been made available to individual districts.

In 1997 an attempt was made to include personal emoluments in the grant in anticipation of the planned de-linkage of personnel from the civil service to join individual District Health Boards (see Section 3.5.4). A tentative ceiling of 60 percent of the budget would be assigned to the personnel emoluments component. As with the decision to abandon adjustments for existing infrastructure, this reflected a potential improvement in the geographical distribution of resources, and thus equity, through enabling a higher proportion of the total district budget to follow the population rather than the existing inequitable distribution of personnel.[69] However, the proposed de-linkage was not complete at the time of writing, and so this component of the district budget remains centrally allocated.

6.2.5 Timing and Pace of Movements

In contrast to the Resource Allocation Working Party (RAWP) experience in the United Kingdom (UK) and proposed South African mechanisms for geographical resource allocation, no consideration was given to an eventual target allocation, or to the pace of change towards such a target. This is due in part to the crude nature of the formula developed, but also to the possible

[68] Calculated using MOH district grant estimates from the Yellow Book and the total projected budget from the 1998 strategic plan.

[69] It has not been possible to obtain accurate figures on the geographical distribution of personnel, but it is known that there is a heavy urban and hospital bias in this distribution.

primacy of the objective of transparency. Districts were receiving direct funding from government for the first time in 1994, and the immediate concern was to introduce a population-based, and thus objective, distribution of the limited grant funding. The further refinements to the formula, which have been referred to since that time (e.g., MOH 1997; MOH 1997; interview data), have yet to be developed. As shown in Section 5.3.2, while initial movements showed a move towards a possible target of "equal budget for equal 'need," this has not systematically been the case. The development of appropriate monitoring systems and targets is therefore required to ensure continued movement towards equity. The operational definition of "equity" itself will depend on the concept of "need" adopted, as discussed in Section 6.2.4.

In terms of reallocating resources between levels of care, the Zambian health sector has been both praised for its success in increasing the share of the budget going to district health services and criticized for neglecting the hospital sector.

6.3 Linkages between Different Reforms

6.3.1 Cost-sharing Reforms and Resource Allocation

There is growing international evidence that successful health financing policy reform requires careful assessment of inter-linkages between different reform components, whether between individual financing reforms or between organizational and financing reforms (Gilson and Mills 1995; Gilson 1997b). To date, however, no explicit attempt has been made in Zambia to examine the possible relationship between the two financing reforms considered in this study.

While it is generally accepted that there are significant differences in the revenue raising capacity of districts, this is not reflected in the relative allocations of government funding. To some extent this is due to the relatively disorganized nature of cost-sharing reforms and the limited and unreliable information flow regarding the scope of local revenue generation. For instance, as reported in Section 5.2.3, different sources cite districts as recovering anywhere between 2 percent and 18 percent of recurrent costs or income (Daura et al., 1998; CBOH 1998; Sukwa and Chabot 1996). At the same time, this reflects lack of clarity at the national level regarding the nature and purpose of a resource allocation mechanism and the role of government funding, as well as capacity and data constraints at the central level in terms of designing an appropriate formula.

The national health financing policy has passed through several different drafts, with differing emphasis on whether the role of government funding is to provide an essential package of services to all Zambians or to subsidize key services for the poor where the scope for revenue generation is limited. It appears that the policy is not yet clear on this issue, however, and until clear decisions are made regarding the focus of financing policy, guidelines for implementors and the population as a whole will be delayed.

There has been discussion within the MOH and CBOH regarding the need to more explicitly incorporate poverty as a criterion within any revised formula (MOH 1997). Whether this is in relation to fee potential and thus equity in terms of total district income or more explicit recognition of the linkage between poverty and health need is unclear.

In terms of the policy of reducing the proportion of the budget to hospitals in favor of district level services, this has been accompanied by an implicit policy shift towards local revenue generation and increasing reliance on user fees as a source of funding for day-to-day operations within hospitals.

Both the Medical Services Act of 1985, which gave UTH board status, and the 1995 National Health Services Act specifically refer to the freedom of boards to raise their own resources. However, prior to the closure of the outpatient departments at the third-level referral hospitals, this had a potentially negative effect on one of the efficiency (and thus sustainability) objectives of the reforms. As noted by one review of the reforms in 1995, the increased dependence on fees at the hospital level meant that *"managers [were] therefore less keen than before to discourage unnecessary use of hospital services"* (Choongo and Milimo 1995: 18).

6.3.2 Linkages between Financing Policy and Organizational Reforms

There has been a consistent and clear linkage between the broad strategy of decentralization and resource allocation policy decisions. The decision to allocate government funds directly to districts from January 1994 was an essential component of the decentralization strategy, building on the expressed intention to decentralize not only roles and responsibilities, but to back that up with resources (interview data).

Organizational structures around the management and use of collected revenues have however, not been fully developed within the health system. For one, the interface between the district and health centers in terms of revenue management is weak, resulting in an ineffective arrangement. The stringent accountability required of the health center staff has often discouraged centers from claiming retired funds (Daura et al., 1998) leading to funds being left unclaimed in district accounts. Yet District Health Management Teams to whom funds are retired often do not have to meet such stringent rules about the use of retired funds. In one district, it was found that the DHMT used funds collected to meet obligations totally unrelated to the health activities outlined by the collecting facilities, yet facilities had no recourse once their money was expended (Daura et al., 1998).

On the other hand, the policy of shifting funds upwards with referral cases has had the positive effect of fostering stronger links between the health centers and first-level referral hospitals. As of 1999, all districts now sign contracts and work out modalities for payments with whoever provides first-level referral services. Organizational reforms have also impacted positively on human resource development, especially at the district level where tasks such as budgeting, planning, control over line items within the budget, revenue generation and retention, and decision making have been implemented. Community participation has also been affected, although it may not be at a satisfactory level (interview data).

Attempts to implement effective organizational reforms have been largely successful. As outlined in Section 4, some management and information systems were developed during the process of implementation and so were relevant skills necessary for the effective control of resources at the local level. However, refinement to aspects of some systems occurred later in the process, and this has led to conflicting reports on the success of the organizational reforms. Systems such as the FAMS and Health Management Information Systems were only refined and implemented in late 1998, yet a fee policy was implemented much earlier in 1992.

As part of the reform, local management of health care services was placed in the hands of DHMTs, which have been trained in management and financial planning. The immediate impact of devolution at the district level has been the improvement of accounting, financial management, and planning as well as added skills in priority setting. A prominent policy maker notes that "the capacity of districts to manage their resources has improved" as a result (interview data).

In terms of planning networks, districts are required to consult with the community during the planning process through meetings with a Neighborhood Health Committee (NHC) so that the community plans are included in the overall district plans (interview data). In terms of the management of collected resources, NHCs are again involved in that requests for the release of retired funds must be signed by community members before districts can release the funds (interview data). Although implementation varies from district to district, this is the accepted practice throughout the country. It implies that there is enhanced accountability at the facility level in terms of the management of financial resources.

Organizational reforms, in general, have succeeded in making more efficient use of resources by allocating more resources to the periphery (interview data, UNZA-IHE, 1996) and have further led to the development of an objective criterion for allocating the budget (interview data). Given the resource allocation criteria, budgets have become increasingly transparent and easier to defend when questions arise on line items. Furthermore, the introduction of the resource allocation formula has enhanced the equitable distribution of available resources (interview data). In addition, distortions in allocation of scarce resources resulting from the existence of mission facilities in certain locales have been eliminated by the introduction of the bed grant criterion.

The mere development of resource allocation criteria in a sector where there had been no objective criteria in the distribution of resources has been one of the most notable impacts of the devolution aspect of decentralization. According to the 1995 auditor general's report on the MOH application of decentralized funding, the MOH had the fewest cases of misapplication of government funds and the fewest cases of misappropriation, an indication of the benefits of decentralizing to the districts (interview data). Stemming from this development, the Ministry of Finance made efforts to replicate what was happening in the MOH to other ministries. In fact, the MOH's demonstrated successes in lessening the chances of misappropriation of government funds have led to the decision to devolve the salary component of ministry budgets. MOF no longer pays out salaries, but instead gives the salary component straight to specific ministries who then pay staff (interview data).

Implementation of a weighted per capita formula in allocating budget funds across districts has led to other successes. It has been noted that the MOH has maintained public financing in all parts of the country as a direct result of implementing the weighted per capita formula (interview data).

6.3.3 Relationship with Other Policy Reforms

A user fee policy was intended to be a small part of the comprehensive financing policy of a decentralized health system—a system that included a drug policy, human resource development, essential benefits package, and resource allocation formulae. The implementation of a fee policy, however, has preceded most of the complementary policies. As a result, the fee policy is being undermined by the fact that not enough has been done in terms of developing complementary policies. The essential package, developed for the purposes of increasing efficiency in the use of limited government resources, has never been used to allocate resources since it is yet to be implemented (interview data). In addition, it has never been clear whether collected fees were to be channelled toward the cost of the essential package (interview data).

6.3.3.1 Drug policy

Evidence shows that, in practice, fees are retired to the district level, where they may be used for purposes other than drug procurement (Daura et al., 1998), while drugs continue to flow from the

central level through a logistical distribution network that depends on drug kits donated by donors. Furthermore, it has been suggested that drug kits distributed through this network are often not enough to meet the needs of the catchment areas for whom they are supplied. To date, reports abound concerning consumers' complaints about the lack of drugs at health facilities (Daura et al., 1998; Booth et al., 1995). Studies indicate that consumers would not mind paying if what they were paying for was available. Their lament has been that once they have paid, they are often given a prescription to purchase drugs elsewhere, and they therefore do not see the point in paying (interview data).

Unfortunately, this study did not review the recently developed drug policy, and therefore conclusions regarding explicit linkages with the current financing policy cannot be drawn. A linkage should be assured, however, to the extent that the drug policy reflects the essential package and cost-sharing revenues are viewed as contributions towards the cost of that package.

6.3.3.2 Human resource policy

Cost-sharing reforms have been linked to human resource policy largely through the freedom of districts to use revenues to employ additional staff. In particular, this has enabled districts and facilities to re-employ classified daily employees (support staff such as cleaners and security guards) who had been retrenched as part of a broader government policy to reduce personnel costs. While this has a positive impact on sustainability by reducing financial or material loss and enhancing quality through cleanliness, differences in the capacity to generate such revenues mean that the impact has not been uniform around the country.

In addition, the effect of drug shortages elsewhere in the system, and the adverse effect on utilization caused by payment for attendance rather than for treatment, is affecting the ability of districts to maintain such casual employees (CE). As one district director lamented, *"Because we have no drugs in the health centre, even the income from user fees has actually gone lower, and so we're not able to keep persons. So we were actually contemplating this morning as the DHMT to decide just perhaps to suspend the CEs until further notice."*

As discussed in Section 6.2.4, the current resource allocation formula is applied to a relatively small proportion of total district funding. The majority of staff costs are not included, although districts accounts clerks are paid through the grant and support staff are sometimes paid using fee revenues as above. Finalization of the delinkage process implies that districts will manage all matters relating to the hire and fire of both trained and casual personnel. This will require consideration of differential staff costs around the country to be taken into account. For example, inducements are likely to be necessary to attract professionals to unpopular or remote areas, and these should be built into any allocation formula.

6.4 Summary

In summary, the evidence suggests that a number of design features of the two reforms of focus have only limitedly achieved the goals of equity and sustainability explored in this report, and therefore there is substantial scope for improvement. At the same time, it is important not to overlook the positive design features. The overall position with regard to design is summarized in Table 6.5.

Table 6.5. Design Features of Reform Process

Design Features Influencing Equity Impact		
	Positive features	***Negative features***
Cost sharing	Demographic and service-based exemptions Relatively low prepayment premium	High fee levels Lack of nationwide strategy for exemptions on ground of ability to pay
Resource allocation	Removal of infrastructure adjustment	Multiple population data sources Initial infrastructure adjustment
Design Features Influencing Sustainability		
	Positive features	***Negative features***
Cost-sharing	Generates some discretionary income for districts/facilities Important source of income for referral hospitals	Excessive benefit package with prepayment in early days Prepayment card subject to abuse
Resource allocation	Progresive shift to district level - Incorporation in routine budget process	Limited scope (nondrug, nonstaff costs only)

7. The Role of the Policy Process in Influencing the Impact of Health Financing Reforms

7.1 Overview: Explaining Successes and Failures

This section addresses the question of how the context, the actors involved, and the processes around policy development and implementation affected the success of financing reforms in Zambia during the period 1991-1998. Previous sections have described the principal reforms, evaluated their success in terms of impact, and attempted to seek explanations for success in terms of policy design. This section discusses the process through which policies were developed and implemented as they are also likely to be a significant factor in explaining success and failure.

A number of questions have emerged from the preceding analysis with regard to the policy on health care financing. For example, why did the development and implementation of policy on resource allocation appear to be more successful (in terms of its impacts) than the policy on user fees? The failure to finalize an overarching health financing policy is significant and the reasons for this need to be explored further. Without such a broad umbrella policy in place, the implementation of specific elements of reform has suffered. There is also a question concerning the factors that led to the poorly designed prepayment schemes introduced in 1994.[70]

Interview data are the primary source for material presented in this section, and the issues it addresses are largely shaped by interviewee responses. In terms of the actors involved in the policy process, interviewees generally agreed that ministers of health had played a central role in shaping financing reforms. Each successive minister brought his or her own particular background and policy concerns to the table. At times ministerial commitment to a particular reform helped catalyze both policy development and implementation, but ministerial decision making also had adverse effects, such as frequent changes in, and reversals of, policies providing an uncertain base for implementation.

No other single group of actors was as significant in determining financing policy direction, but donors, technical advisors (both internal and external), and the Health Care Financing Working Group all influenced particular processes and decisions. For example, donors' openness to forms of financing other than a nationally driven user fee system allowed the possibility of exploring prepayment and other forms of insurance. The lack of constancy in the HCFWG, and the political maneuvering that undermined the authority of this group, was one of the factors hindering the finalization of the financing policy.

In terms of the process of financing policy development in Zambia, interviewees consistently noted the importance of the guiding vision—how the broad principles of health sector reform aided the development of specific financing policies. They also frequently cited the importance of effective

[70] See table 7.3 for a summary of key policy successes and failures and explanatory factors.

consultation and communication. Although it was perceived that there was often effective consultation around reforms, the process of communicating reforms to health care workers and the general public appears to have been neglected.

As in many developing countries, limited capacity appears to have been a key constraint to successful policy formulation and implementation. Additional issues that emerged from the interviews concerned piloting and the sequencing of reforms and the lack of monitoring and evaluation conducted.

Section 7.2 explores the significance of the context of reform; Section 7.3 analyzes the role of particular actors, why they behaved as they did and how their behavior influenced policy successes and failures; 7.4 and 7.5 move on to consider the process of policy development and implementation, respectively.

7.2 The Relevance of Context to Reform Substance and Processes

The health sector reform agenda was developed within a political context that was amenable to radical change, as the Movement for Multiparty Democracy's motto "the hour has come" suggests. The MMD manifesto articulated the problems within the health sector and thus helped create expectations for change. Part of the impetus for reform was clearly the political context—a new government was coming to power for the first time since independence, and high hopes accompanied this transfer of power. Consequently the political level, particularly ministers of health, played a key role in reform. As one Ministry of Health official observed, "*the political momentum often outstripped the technocratic.*"

Another element of the broader context was the reestablishment of relationships between the Zambian government and the World Bank and the International Monetary Fund after a long suspension during much of the 1980s because of debt servicing arrears. The reestablishment of such relationships held the promise of new sources of financing for a resource-starved health sector; however, MOH officials sensed that a clearer policy agenda would be required to receive such funds:

The initial thing which seems to be driving the health policy thing was that at that time Zambia was building its bridges again with the World Bank, both at the macro-economic policy level and sector level, and there was a feeling then within the government, within the ministries, that in order to be equipped for this type of dialogue with the Bank, in order to be equipped for some further resource mobilization that might become possible, we need to have a policy, the ministry needs to have a policy. (donor representative)

While the overall context appeared conducive to reform, Zambia's MOH went further than any other ministry in seizing this opportunity and developing a truly radical vision of a new health care sector. Reforms in the health sector, during the first half of the 1990s, were by all accounts significantly ahead of reforms in other sectors, as one technical advisor to the Ministry of Finance observed:

I think there was basically a feeling that the Ministry of Health was significantly, I mean much further down the road than other Ministries, and they had a vision, they had a dynamic Minister in Kawimbe. (technical advisor)

This sense among the broader group of policy makers that the MOH was "ahead" of other ministries was probably a double-edged sword. Although the MOH's reputation for being more

organized than other ministries was one of the factors enabling it to proceed with radical reforms, it also meant that there was weaker external support and monitoring from other branches of government, as the same respondent from the MOF observed:

So I think there was a confidence and a feeling that you know Health knew what they were doing, they had a much better focus on the issues than we did, so we were quite willing to play ball with them, to let them, you know, take the lead, and initiate… I think we were a bit lax in a sense that because we had confidence, perhaps we were too confident. (technical advisor)

Although it is difficult to be certain, stronger monitoring from the MOF may have helped ensure that, for example, revenues from cost sharing were better accounted for, and better used.

Ultimately the fact that such far-reaching organizational reforms were undertaken prior to the development of a broader government policy on decentralization may also have been problematic. This broader policy envisages devolution to the district level of local government, and it is yet to be seen how, if at all, this will mesh with the established District Health Boards.

Although the political and bureaucratic context was supportive of reform, the broader economic context, as described in Section 3, was very difficult. The MMD government inherited a large burden of debt, and despite renewed relationships with the international financial institutions and initial donor optimism, the high debt burden and consequent need to allocate government resources to debt servicing continued to place significant stress upon the government's budget. The shortage of government funding was further exacerbated by failure to privatize the copper mines in a timely manner. Thus, despite the fact that the government during the early 1990s increased the percentage of the government budget allocated to health, there were declines in the real value of the health budget (see Figure 3.2).

As data in Section 3 show, Zambia is also one of the most impoverished countries in the world with 85 percent of the population earning less than US$1 per day. Widespread economic stress, and resulting malnutrition, contributed to deteriorating health indicators, particularly among children. Morbidity among adults also increased due to the high prevalence of HIV in the population. Together these factors put increasing demands on a fragile health care system.

The combination of decreasing resources and increasing demands suggests that there would most likely have been significant problems in the health sector, regardless of what policy was in place. This context also created difficulties for the reforms of focus, particularly cost sharing. Against a background of widespread, and reportedly increasing, poverty across the country even well designed and implemented cost-sharing policies would probably not have been well accepted among the population. Furthermore, given the budgetary context, it seems almost inevitable that health staff would look to cost-sharing revenues as a key to increase resources. The implications of the economic context for resource allocation policies are less clear as such policies focused on reallocating available resources rather than raising more resources. It could be argued that the unstable economic environment contributed to the acceptability of the resource allocation formulae: in a context where nominal budgets changed considerably from year to year (due to inflation) and expenditure frequently did not match budgets, changes in budget due to a new resource allocation formula may have provoked less concern than they would have in a stable economic environment.

7.3 The Actors' Influence on Policy Successes and Failures

7.3.1 Ministerial Influence

Ministers of health commonly have significant and legitimate influence over policy development and implementation. During the period of study, the ministers of health in Zambia were faced with a particularly complex set of problems. As highlighted above, social and economic factors were placing increasing strain upon the health care system; at the same time there were high expectations of what a new, democratic government could achieve. As one respondent suggested:

> *It is not a very easy job to be minister of health in this country with this reform. I think no minister will ever do well beyond two years, because things are changing so quickly, and people's expectations are changing, and so it is difficult to maintain. (health official)*

Ministerial influence is likely to be significant, particularly in contexts where there is a relatively weak bureaucracy. In Zambia, particularly for the financing reforms of focus, there was limited technical capacity within the MOH. It is not particularly surprising, therefore, that the political team at the head of the MOH influenced the path of reform. This section focuses on the role that ministers played in the policy process and the implications of that role regarding policy development and implementation. By necessity the section discusses the influence of individual ministers; however, the aim is not to consider the influence of particular personalities but rather how the context and organizational structure affected how the ministers wielded power.

During the period under consideration, four different political teams have led the MOH (see Table 7.1). Broadly speaking, during the first and third periods the initial reform vision, as encapsulated by the National Health Policies and Strategies (NHPS), most clearly influenced policy action. The second and fourth periods saw the introduction of approaches different from those articulated within the NHPS.

Table 7.1. Key Features of the Political Partnerships within the MOH, 1991-1998

Period	Political leadership (Minister, Deputy)	Position
Nov 1991 - Jan 1994	Kawimbe, Kalumba	Prior involvement in policy development through Health Advisory Group Supportive of reforms (though the two Ministers gave emphasis to different reform elements)
Jan 1994 - May 1996	Sata, Kalumba	No prior involvement of minister Ongoing input from Kalumba, though in a less supportive political environment
May 1996 - Mar 1998	Kalumba, Luo (from Nov 1996)	Kalumba pushed forward NHPS reforms Low profile of deputy
Mar 1998 to Oct 1999	Luo, Mwansa	Minister brings new ideas, different from those of the original reform vision Low profile of deputy

The evolving role played by Kalumba, who was widely seen as the architect and visionary of the reform program, may have determined to a considerable extent the position of other ministers. By all accounts the NHPS document was formed by merging some of the technical work conducted by civil servants in the MOH prior to elections with some "*very strong principles about reform*" (health official), which came primarily from Kalumba. These strong principles emphasized the importance of partnership and a democratic approach to governance of the health sector (interviewee data). After the MMD election, the appointment of Kalumba as deputy minister of health was a clear indication that Kalumba had a role in shaping MMD policy. Shortly after the elections, Kalumba and Kawimbe had an audience with the president where they gave him a full briefing on the proposed reforms (interview data). This reinforces the notion that there was a high level of political support for the reform program.

Kawimbe's background as a medical consultant initially gave his policy concerns a more clinical focus:

> *Kawimbe was not really fully on board with all these policy idea. He had quite a clinical view of health and health care. He originally wanted to change the ministry to look like a university teaching hospital, almost, you know, with a Department of Obstetrics, and this and that. (donor representative)*

As minister, Kawimbe gradually became more committed to the reforms set out in the NHPS. His appointment as focal point for the Program to Prevent Malnutrition during the drought in 1993 also exposed him to the dynamics of grassroots activities, which in turn contributed to his enthusiasm for the Mwase Mphangwe Initiative (i.e., prepayment in kind).

> *The minister had got so interested in communities and so on; really the drought helped to get him out of the office and he was a politician anyway in many respects, as a Minister is, so it was interesting. It opened up dialogues for him, and when he came back from Eastern Province where he'd handed over a vehicle to one of the districts and they'd got into all this discussion about recurrent costs, and about the possibility of providing sacks of maize as a payment, as a prepayment for the support to the health care system. (donor representative)*

> *Kawimbe was also seen by several observers to be one of the driving forces behind cost sharing. He saw cost-sharing revenues as a means to improve health worker remuneration and drug fees as a mechanism through which pilfering of drugs may be controlled by linking drug dispensing to a fee that would need to be collected and recorded (interview data). As a result, at least during this first period, the ideas of the minister and deputy minister were usually, if not always, compatible. The deputy minister was allowed considerable leeway to develop further policies on organizational restructuring, which were to lead to the radical program of decentralization and shifts in resource allocation policy.*

By contrast the second period, during which Sata was minister of health, was characterized by disagreement between minister and deputy minister, and this was apparent both to MOH officials and external actors such as donors. On his appointment, Sata reversed many of the reform ideas implemented or discussed during the previous minister's post. Fees for drugs were rapidly repealed, plans to expand prepayment (along the lines of the Mwase Mphangwe Initiative) were diverted in a completely different direction, and the scope for the deputy minister to develop further reform plans was limited. Even those health officials who were committed to the reforms as set out in the NHPS believed that confrontation with the new minister was likely to be counter-productive.

but when [Sata] came there he was in a hurry for whatever reason, to put his mark on it…it actually boomeranged, it misfired.

Sata was renowned as a consummate politician, having held senior positions in the United National Independence Party and MMD governments. He primarily played the post of minister of health to increase his own personal standing in the government, carefully nurturing links with influential individuals and groups. Sata found his main power base within the health sector among hospital staff, whose power and resources were perceived by some as being eroded by the reform ideas taking shape under the deputy minister. The sudden announcement of a hospital-based prepayment scheme reflected these various preoccupations: a need to reverse the ideas of the former minister and deputy minister while at the same time building a new power base.

When Kalumba was promoted to minister in 1996, he moved rapidly to reassert the original thrust of the reform program. Hospital-based prepayment schemes, which had proved highly problematic, were rapidly closed down (with the exception of "high cost" schemes that were offered privately) and shifted to the district level. The Central Board of Health was formally established. He restarted work on the development of a comprehensive health financing policy in 1997.

Kalumba, more than any other minister, had an intellectual commitment to health sector reform that dated back at least to his years as a graduate student at the University of Toronto in the 1980s where he completed a doctoral thesis on "The practice of health sector reform in Zambia." By his own account there were multiple, often external, influences upon his thinking. In interviews he mentioned a number of networks of friends and colleagues, such as academics at the University of Zambia, participants in the World Health Organization (WHO)-supported Health System Research Program for Southern Africa, members of the Forum on Health Sector Reform, and technical advisors who had worked in Zambia who influenced his thinking. In addition, prior to taking up his position as deputy minister under the MMD government, Kalumba had worked as a consultant addressing issues such as HIV, malnutrition, and the impact of structural adjustment in the Sub-Saharan African context. This background enabled him to gain firsthand experience of health systems and structures in both African and industrialized country contexts. Kalumba was thus much better informed about international debates on different aspects of health care financing than other ministers and had some strong opinions concerning such issues as the limited prospects for social health insurance schemes and the need for prepayment schemes to be operated by District Health Management Teams rather than at the hospital level.

At the beginning of the reform program, one of Kalumba's core concerns was the imbalance between rural and urban areas in resources:

As I said, before 1991 I had been very actively involved in research, particularly to do with rural health development issues, and was concerned very much with the quality of rural health care and the imbalance of resource allocation to urban areas, in favor of urban areas.

This concern is clearly reflected in policy development on resource allocation mechanisms. Because of his commitment, Kalumba came to be perceived by some as "anti-hospital" and pro-primary care. Ministers with whom he co-existed (such as Sata and Luo) appear to have defined their position by being more sympathetic to the concerns of large hospitals.

On hindsight, I think I also made a strategic mistake. My thinking was how to recast the status of these hospitals within our national health care system, and that recasting was being understood by our colleagues in the hospitals as a way of downgrading them. I never succeeded in communicating the right-sizing idea as a non-negative idea.

Kalumba's focus on reorganizing the system as a whole inevitably led him to work with a different group of professionals within the MOH, who were part of the Health Reform Implementation Team but were not necessarily physicians and were less likely to come from one of the big hospitals. Kalumba himself considered this to be a mistake as the way in which he encouraged the development of this cadre built up resentment and ultimately resistance among senior professionals in hospitals who had neither the same high level of involvement in policy formulation nor substantial improvements in pay and perquisites:

> *I think there's another aspect which I consider as a strategic mistake. The building of the HRIT team, and…the existing visibility of people in this team who were perceived by people in the hospitals as juniors, was also a very big problem. People saw all these guys at HRIT as juniors; they considered that they were not really medics, so to speak, they had not made it to the specialist, super-specialist quality…I didn't manage that properly.*

This period of rapid reform activity ceased in March 1998 when Kalumba was moved to become minister of tourism and was replaced by Luo. Although Luo had been involved in the reform program early on, even participating in the MMD health committee prior to elections, and Kalumba clearly saw her as his successor, her actions on coming to power led to a slowing down of reform implementation. Although the draft financing policy was near completion when Luo became minister, it has not to date been finalized. During the first three months of her tenure the new minister imposed a total ban on workshops, and after this period workshops were discouraged; this also slowed further reform implementation such as roll out of the guidelines on cost sharing. More fundamentally, some of the architecture of the reforms such as the establishment of the CBOH, regional offices, and district health boards were reviewed and in some cases reversed. During late 1999 regions were abolished, provinces re-established, and organizational restructuring of the MOH and CBOH approved.

There were probably a number of factors driving Luo's actions. Certainly by the time she came to power there was increased concern among donors to show "results on the ground" i.e., solidify the reforms that had already taken place rather than implement further reforms (interviewee data) and refocus health care services and health care practitioners on service delivery. These concerns are consistent with recommendations from the evaluation conducted by MOH/WHO/ UNICEF/WB (1996), which noted that, "*support for the districts should be more oriented towards making the existing system used and operational, rather than introducing many more new concepts and initiatives."*

One donor representative suggested that Luo's openness to more clinical concerns relating to the process of health care delivery was refreshing after the strong focus on systems:

> *If you said nutrition – this happened to me, I experienced this – if you said that 43 percent of Zambian children under five are stunted, they were like, 'whoah, you are a verticalist'. You couldn't even talk about technical issues without being labeled. It was that severe, the culture, and that was one of the positive developments from our perspective with the new minister, that she recognizes for a health reform process as magnanimous as the Zambian health reforms are, you have to show results, people have to feel the benefit.*

However, Luo's actions suggest that she also had fundamental concerns about the directions of reform and the limited emphasis of the hospitals' role within the health system, not just the speed and lack of on-the-ground impact.

The ministers' personal contacts also influenced the direction of reform. Kalumba's close association with the president and early involvement with MMD probably lent substantial support to the reform program. Kalumba was a founder member of MMD and his coming into politics had been influenced by personal contacts with Chiluba (interview data). Kawimbe was closely associated with the then minister of finance (Kasonde), and this association undoubtedly eased the way for the MOH to opt out of the Provincial Accounting and Control Unit system and fund districts directly.

Not only did the ministers differ in terms of the content of their policies, but also in their styles of management. Kalumba was particularly concerned about ensuring adequate consultation both from a technical perspective and as a means of securing support for reforms during the policy development process. In contrast, Sata tended to be much more autocratic and much less consultative, even ignoring technical advice, as the process behind his announcement of hospital based prepayment schemes reflected (interview data).

There are a number of reasons why ministers of health in Zambia played such a critical role in the formulation and development of financing reforms. First the context is important: the reform program was initiated immediately after elections, which for the first time since independence brought a non-UNIP government to power. It was inevitable that MMD would be very motivated to demonstrate what a new government with new ideas could achieve. Political ownership of the program was paramount. In addition, the personal charisma and power of individual ministers led them to stamp their personal imprint on the reforms. Sata was always perceived as powerful. Kalumba, although not powerful at the beginning of the reform period, always exhibited a charismatic leadership style and clearly grew in stature during his tenure at the MOH. Kawimbe combined elements of both.

Furthermore, reforms in the health sector were significantly ahead of reforms in other sectors. Hence, power and charisma were certainly important elements in "selling" reforms at the cabinet level and to other stakeholders:

> *The effectiveness with which you could sell a policy during my tenure as Minister of Health was influenced by the political strength you held. If that was weakening, it became very difficult to sell any new policy initiatives actively. (former Minister of Health)*

Without political spearheading of reforms it seems unlikely that much progress would have been made.

A further factor that may have influenced the importance of ministers in the reform process was the lack of ownership of reforms at the top level of the civil service and the relative lack of technical expertise on health financing issues, both within the MOH and among economists outside government. While there was undoubtedly a group of highly committed and skilled individuals within the civil service, many of whom played a significant role in explaining and advocating reforms to health workers and other groups, there was no clear policy champion who could articulate the reform program in political settings. More recent reform initiatives, within the education sector for example, have been led by the permanent secretary, and as such are perhaps less prone to frequent reversals of policy associated with ministerial spearheading of reforms.

7.3.2 Donors

Continued pressure from donors in their bilateral agreements has assisted the ministry in adhering to its reform plans, including budgetary reallocations, and helped it to not be pushed off path by short-term political interests.

The description of the reforms in Section 4 suggests that donors frequently did not play the typical roles commonly attributed to them. In the words of a former donor representative:

> *What's interesting in all this is that the [World] Bank seems to have been not living up to its traditional identity; you know they weren't sort of running around promoting fees. I think they were more interested, at least the people who came, with a certain galvanization of the sector, a certain sense of ownership, amongst the different players at different levels of the sector. They certainly did not jump in and try to shape or distort the process as sometimes overenthusiastic big donors can.*

An external technical advisor from another donor agency commented:

> *There was also a strange mix of WHO and World Bank, resulting simply from the background of the individuals involved. The Bank provided a lot of support on health sector priorities through its public health input, and WHO provided support on health financing policy. Not the usual mix, but it reinforces the notion that with these (and bilaterals as well, I would guess) agencies, 'what you get depends on who you get.'*

Besides emphasizing the importance of individuals over the organizations they represented (which is discussed further in Section 7.4.4), these statements suggest that many donors in Zambia came to the reform process with relatively open ideas about what package of reform elements would be most appropriate. This is supported by the former UNICEF representative who commented on the role of a policy discussion group established with UNICEF involvement prior to the 1991 elections: "*The idea was really just to get some sort of policy discussion going, just get some options on the table."*

This is despite the fact that at this point in time UNICEF New York was actively advocating a particular form of cost sharing, namely the Bamako Initiative, and that much of the technical assistance brought by UNICEF to Zambia was funded by the Bamako Initiative. This openness to alternative financing approaches allowed the government to explore different forms of cost sharing in different parts of the country and cohered well with the decentralized approach to cost sharing subsequently adopted by the government. It also allowed the government to focus on financing policies other than cost sharing. For example, the policy discussion group cited by the UNICEF representative actually played a greater role in pushing the decentralization of financing than any form of cost sharing.

Although on occasion there have been tensions between donors and the MOH, to a considerable extent there has been an allegiance between middle and high- level reformers in the MOH (and CBOH) and donor representatives. On occasions when the political environment has not been supportive to reform, reformers have looked to donors to provide external pressure. The most obvious case where donors helped to catalyze financing reform processes was around the decentralization of funding to the districts and the development of "basket funding." Although MOH was planning to move in this direction, donors actually implemented basket funding to districts in July 1993, prior to government funding flowing in this manner in March 1994. In the words of a former MOH official:

We, and by we I mean the Ministry of Health and the donors, had a series of meetings at which we decided that we needed to demonstrate to the MOF (Minister of Finance) that putting money in the district was a better alternative than controlling money from the headquarters in Lusaka. So we decided that the donors themselves were going to initiate the budgeting of funds directly to the districts.

The substantial interest that the reforms generated among the donor community, and consequently the funding that came into the Zambian health sector as a direct result of the reform program, also helped to bolster political support for reform. In the words of a former minister, it helped senior politicians see that "*these ideas meant money*."

Certain donors played an active role in marketing the reforms to other donors. This was particularly true of the representatives of UNICEF and WHO, who had been involved in the reforms from the beginning, and later on the USAID health officer:

They became very instrumental in facilitating the networking, the selling of the new policy reform ideas, to the other players. (former Minister of Health)

While in general respondents felt that donors had played a very supportive role in the reforms, a few observers noted that over time, particularly as the reforms became higher profile, there was more competition between donors, and less willingness to be guided by Zambian ideas.

So there has been a shift, and I wouldn't say that the Zambians are being pushed around, but I think they do have less leeway and that the amount of in-fighting amongst donors was never there before; everyone was supporting the process that was going on, and they still are in the sense that they will all say that they are committed to the Zambian reforms, but there is more territorial struggle going on between donors than there was before. (former technical advisor)

7.3.3 Technical Advisors

As described in Section 4, a large number of external technical advisors, both long term and short term, worked in Zambia on health financing related issues. These technical advisors were funded by a variety of different donors, including the Swedish International Development Agency (SIDA), WHO, UNICEF, USAID, and until recently no one donor had a large number of advisors on health financing in the field.[71] It is considerably to the government's credit therefore that they managed to utilize this diverse set of advisors. Virtually all the long-term advisors appeared willing to accept and fit in with the vision of reform as articulated by the Zambians and use their technical skills to further this vision.

SIDA had people placed within the ministry; they were not functioning from outside and they were very much trusted and seen as part of the team. (former technical advisor)

Although SIDA assistance at the time was more focused on general planning than financing issues, this statement summarizes the position of many technical advisors. No one single technical advisor appeared particularly influential.

[71] The current USAID-funded, ZIHP project has brought in a team of technical advisors whose remit covers reform issues generally but with a substantial focus on health financing issues.

Long-term technical advisors were often fully integrated into the decision-making process, holding positions on the HCFWG and accepting full responsibility for pushing pieces of work forward. On the whole they did not act in an "advisory" role working through local counterparts. This was largely because of the lack of capacity within the MOH (see Section 7.5.1) and hence the inability of the MOH to identify suitable counterparts. While the direct involvement of external technical advisors in the policy process probably speeded up the pace of change, it also on occasion led to problems. Several technical advisors expressed concern about how advisors were sometimes able to push reforms ahead without the full involvement of the MOH, and there were at times a temporary suspension of activity as one advisor left and was not immediately replaced. For example, between 1996 and 1997 there was a hiatus between the departure of two long-term health financing advisors and the arrival of the new team.

While respondents interviewed during this study commonly recalled many of the technical advisors, they were much less likely to cite a particular piece of work completed by a technical advisor or the impact that a particular technical advisor had upon policy making. Occasionally an insight provided by a technical advisor appeared to have provided an impetus for change. For example, while the then minister of health (Kalumba) was explaining to an audience at WHO the problems Zambia encountered in putting an overarching financing policy in place, a WHO staff member, who later acted as a technical advisor, observed that an outline of a financing policy had already been created by the organizational reforms put in place (interview data). This observation or insight was one of the things that stimulated the resumption of work on the Health Financing Policy in 1997 (interview data, former minister of health), although the change in minister, and the push by donors (especially SIDA) for such a policy, were also significant factors.

There appear to be a number of reasons why specific consultancies or studies on aspects of health financing did not directly translate into policy. Sometimes the thinking of short-term external consultants was not sufficiently in line with government thinking. For example, a consultant's work on social health insurance was never translated into policy, perhaps due to the fact that Kalumba was always doubtful of the relevance of this type of model of insurance to the Zambian context:

> *[the consultant] was very motivated in trying to help clarify, work with us on the health financing issues, but I noticed that she was really driven by the ILO paradigm, of social security, social insurance programs and so on. But I had… become a little cautious about the social insurance schemes.*

Other reports were simply felt to be indigestible. For example, a CBOH official described the output of a consultancy on financial systems, a possible procedures manual, in these terms:

> *So XXX eventually came up with a final report, and this report actually happened to have been very, very bulky.*

Fortunately in this case the report was felt to be of such importance that MOH and HRIT officials themselves prepared a more concise version, following a workshop to discuss the initial output. With the trial project on decentralized budgeting, the decision to move to scale had been taken prior to the evaluation, although the evaluation did perhaps help the MOH refine its approach to decentralized budgeting.

Occasionally studies led directly into policy or operational changes. This was the case with the district cost-sharing study conducted during 1997, which directly influenced the development of the overarching Health Financing Policy (interview data) and also provided guidelines for districts on cost sharing. However, some respondents expressed concern about the ad hoc manner in which

certain consultancy findings were translated into action whereas others were just ignored. Those that were translated into action were not necessarily priorities but "*rather reflected the follow-up of an external advisor*" (technical advisor). For example, with the cost-sharing guidelines, a program of implementation was mapped out, but collapsed after a short while as the donor changed funding arrangements.

Another technical advisor expressed similar concerns about how technical advice may distort local policy processes. Although strong local ownership of the overarching financing policies clearly existed, the way in which these policies were translated into operations was sometimes left to technical advisors who could imbue policies with a very particular flavor.

> *Specific expatriate advisors might have had considerable influence over the nitty-gritty of reforms, like for example the FAMS system. I think that their own perspectives might have led the way that they designed it. So perhaps the FAMS system isn't so sensitive to local management needs, but more the need for upward accountability including reporting of donor funds. (former technical advisor)*

During the period under review SIDA shifted its mode of providing technical support from offering long-term technical advisors placed (largely) in the planning unit to providing institutional support for the development of health economics capacity at the Department of Economics, University of Zambia. This has had some degree of success, moving from a situation in 1993/94 where there was just one economist from the department working on health issues to a situation where a large number of department staff have some expertise in health and have participated in health sector projects, not only with SIDA support but also with support from USAID and other international institutions.

7.3.4 The Health Financing Working Group

Despite the existence of the HCFWG as a formal body to advise on health financing reform for much of the period under study, the group has had mixed success in actually influencing reform design and implementation. In its earliest incarnation during 1992, it was established primarily as a review body to look at outputs from individual consultants visits rather than as a formal policy advisory group. However, the potential for HCFWG to play a more proactive role in policy formulation was recognized in the inclusion of such a forum within the NHPS.

> *A Working Group on health sector financing has been established by the Minister of Health to restructure, review, and explore financing mechanisms of the health sector. This group would later be integrated into the activities of the National Health Council as a committee on health financing.* (MOH 1992a: 33)

While the MOH issued two important circulars on cost sharing during 1993 (see Section 4 for details), the primary focus of the central level at that time was on district capacity building in preparation for the receipt of donor funds. Many HCFWG members were absorbed in training and preparation for decentralized funding, and hence there was no formal meeting of the working group that year.

In early 1994 HCFWG was reactivated in response to an announcement by Minister Sata regarding the introduction of prepayment schemes at major hospitals. The perceived role of the HCFWG appears to have been to insert some rationality and planning into a politically driven process. However, at this time Sata had established an advisory group of his own on prepayment, and

this undoubtedly reduced the influence of the HCFWG. In contrast, Sata's group involved primarily the executive directors of several large hospitals (reflecting his power base within the hospital sector) and involved no one with a technical background in health planning or finance. Despite meeting quite regularly and involving a number of senior policy makers, local academics, and representatives of the private sector, the general feeling of members of the HCFWG was of impotence and frustration.

The overwhelming view of former members of the working group on the reasons for this lack of effectiveness in influencing policy direction and implementation during the period 1994 to 1996 is that the political climate within the ministry was wrong, in large part due to the personalities of individual ministers (see 7.3.1). This view was echoed by past and present MOH/HRIT/CBOH officials, Zambian academics, and expatriate advisors involved in the HCFWG over that time, as indicated in Box 7.1.

Box 7.1: Former Members' Views on the Lack of Effectiveness of the HCFWG, 1994-1996

"I think the environment in which the Finance Working Group was working was not the type that would respect the approaches. The approach of the Financing Working Group is to discuss through issues, to structure, and to introduce them stepwise... We have had four changes of minister, and in all cases, the ministers at the top were not process people. They were immediate result kind of persons..." (former MOH/CBOH official)

"...the driving process behind the technocratic process was the health reform process with which it was moving in tune - since the Financing Working Group was an integral part of the HRIT. The political process was driven by who was minister of health at the time, and quite often made no reference to the technocratic process." (former MOH official)

"...one negative thing was, nothing to do with the [HFWG] as such, but I think there was too much interference from the ministry. The whole reason why it sort of flopped was the minister [Sata] trying to interfere, so, yes, I think that was sad." (Zambian academic)

"The health care financing group was not given the mandate it should have had to serve as a useful advisory group and to develop and propose a health care financing policy." (former long-term TA)

An additional factor revolved around the nature of the personal relationships between Minister Sata and Kalumba, his deputy at the time, as discussed in Section 7.3.1. The impression among the technical staff and advisors was that the HCFWG was seen as Kalumba's "baby" and therefore was not respected by the minister. Ultimately this was demoralizing for members of the group, as one Zambian academic and former member of the HCFWG recalled:

I remember there was supposed to be a meeting at UNICEF and we all went there, and Sata was supposed to come and he didn't come. And there was some controversial issue which we were supposed to sort out with him but he didn't come, and so after that we rarely met.

A further problem stemmed from the membership of the HCFWG. In common with other committees within the ministry, the perceived need for widespread consultation meant that membership expanded continuously resulting in a situation where *"it became very large in terms of its actual and potential members, and we never had the same group meeting two meetings running, so it was rather difficult to ever make progress on any issues."* (former long-term TA and HFWG member)

The HCFWG was reconstituted and reactivated in 1997 after Kalumba had been appointed minister to oversee the process of developing the official health financing policy. Although broad

terms of reference were developed and agreed, as shown in Figure 4.3, the group concentrated only on one element, i.e., review of the successive drafts of the health financing policy. Early on in the process (between June and September 1997), small working groups involving people not formally members of the HCFWG were established to draft or redraft particular parts of the policy.

During 1998, financing issues appear to have been fragmented, with separate working groups established within both the MOH and CBOH to look at individual issues, but without any sense of overall coordination from either the MOH or CBOH. By the end of 1999, separate working groups existed for cost-sharing guidelines and national health accounts and are proposed for resource allocation. Although there is common membership within these groups to some extent, there is no formal recognition of the role of the HCFWG as an overall coordination and advisory body to ensure cohesion and comprehensiveness in the area of financing.

The reasons why the HCFWG has failed to play a preeminent role in terms of coordinating financing policy development since 1997 are unclear. The fact that it tended to see its remit in terms of shepherding the process of developing an overarching financing policy document has probably worked against it. As the change in ministers sidelined this process, the central purpose of meetings evaporated:

At that time it was felt as, it felt like that development of financing policy was a high priority, something that needed to be done fairly urgently, and therefore they had meetings maybe every three weeks or so, between the workshops, and then also for some time after the second workshop in September. After that, other things became more important, I think, to the ministry, and the ministry is still the coordinator of the working group, so things were sort of left a little bit, or it took longer. (technical advisor)

More fundamentally, the group has had a checkered and inconsistent history, and arguably has failed to establish a reputation as the primary steering group for financing policy. It would seem that the main reason for this is the group has no or inconsistent political backing. Lack of a clear definition of its role and how it relates both to the MOH and CBOH may also have hindered the effectiveness of the group. The fact that it did not have an agreed role or place in the newly defined organizational structures meant that it was easier for policy makers to bypass HCFWG, if they chose to do so. Although the effectiveness of the group is constrained to a certain extent by the limited technical capacity within Zambia, this was clearly not the principle reason for the problems it encountered. HCFWG has consistently been the main repository of health economics and financing skills in Zambia and hence the obvious place to seek support for development of health financing policy.

7.4 Policy Processes

Many different aspects of the policy process could be explored. This section picks up on key themes identified by respondents closely involved in the processes as being important explanations of the way things happened and of the successes and failures in terms of impacts. The following themes are discussed:

- The importance of the initial vision of reform
- Consultation and communication in policy making
- The relationship between policy development and policy implementation

> The personal nature of policy making.

7.4.1 Importance of the Vision

Many of those interviewed for this study emphasized the centrality of the original vision to the future reform program:

There was a general feeling that things could be improved and that we, all of us involved in the process at that time, were given the chance to change things; the sky was the limit and nothing was impossible. (former technical advisor)

So we had to give some, a vision, a dream to the Zambian people, and that's the dream we gave, and it's very much from … Managing for Quality. (health official)

When I took over the Ministry of Health, it was really like being in a jungle, it was like somebody parachutes you into the middle of some tropical rainforest and you really don't know what to do. Did you begin by bringing in more drugs, improving the conditions of service, retraining people? You know, it was a jungle of problems, and my feeling at this point in time was one needs a compass. We need a map, we need a road map, to guide us, ok. And this compass or road map was really what we thought the reforms were all about. (former Minister of Health)

The vision was important not only as a guide to action but also as a source of inspiration to many of those involved in the reforms. Moreover, the process through which the NHPS document (generally seen as the fullest description of the vision) was arrived at helped to bind together a fairly diverse set of actors and expand the sense of ownership of the reform program. As described in Section 3.5.3, the NHPS document built upon the MMD manifesto and the work by the MMD health advisory group, work which had already been completed by senior officers within the MOH, as well as some locally grown initiatives (such as the trial project on decentralized budgeting). Furthermore the process through which the NHPS document was refined, i.e., a series of small-scale meetings in Livingstone involving a number of key stakeholders at different levels of the system, further spread the sense of ownership.

With regard to financing policies, the resource allocation policies more or less came from the NHPS document and its vision. The pattern of decentralization proposed by the NHPS document clearly necessitated reform of the resource allocation mechanisms in use. Furthermore, the trial project of budgetary decentralization and initiatives to strengthen district management provided foundations upon which to base a new format for budgeting and allocating resources. Finally, and perhaps surprisingly, reform of resource allocation never became as sensitive a topic as that of cost sharing, hence it was politically easier to adopt the proposals that technicians made on this topic, in line with the NHPS, and there was less need to adapt the reforms to make them more politically palatable.

For cost sharing, however, it was not clear how to take this particular policy area forward, as the multiplicity of possible options outlined in NHPS indicates (MOH 1992a). Kalumba acknowledged contradictory forces affecting the cost-sharing policy:

I was wary of the need; of how, yes, one, we needed cost-sharing methods; two, we had to be sensitive about how we introduced them. District financing [i.e., the notion of decentralized financing] I think was clear.

The politically sensitive nature of user fee policy exacerbated the problem:

The whole user fee thing was never quite synchronized into the bigger picture because it is something that attracts attention. (donor representative)

Consequently, cost-sharing policy developed as a parallel, separate process depending considerably on ministerial decree rather than linking into the over-arching reform process. Ironically, this form of policy development (i.e., ministerial decree and statements) appears to have made cost-sharing policy even more visible and politically sensitive, without providing scope for adequate explanations of the rationale and purpose of cost sharing and how it relates to the overall program of reforms. As a consequence, there have been widespread reports of the general public associating the program of health sector reforms simply with paying for health care (Booth 1995; Choongo and Milimo 1995; MOH/WHO/UNICEF/WB 1996; Daura et al., 1998), an association that is clearly damaging for the reform program.

One of the key points that has been unclear regarding cost sharing is whether or not financial contributions from the general public to health care providers were merely token, to give them a greater sense of ownership in the health care system, or whether they really had a significant role in terms of revenue raising. As one external review noted:

The user fee policy in Zambia, however has been controversial and inconsistent, oscillating between considering charges as a cost-sharing tool for revenue generation and viewing them as an exclusive strategy to foster popular responsibility /involvement. (MOH/WHO/UNICEF/WB, 1996)

Early circulars on cost sharing emphasized the changing macroeconomic context:

…the simple reason why Zambians are now being asked to contribute towards health care costs is that the Government of the Republic of Zambia, through the Ministry of Health, has limited resources with which to continue to provide free medical care and improve the rundown health infrastructure. (MOH 1993)

In the words of the minister at the time:

We said out of pure necessity, because of changed circumstances on the ground, every able-bodied Zambian earning an income must make a contribution towards health care.

Later on, however, cost-sharing contributions were talked of more as token contributions to cultivate the notion of partnerships with communities. There was certainly a rationale for using fees with this purpose, as one MOH official observed about the situation prior to the introduction of fees:

Literally nobody complained because you can't complain when something is free, especially in the African culture. It's good to see people complain.

Despite the lack of clarity in the minds of senior policy makers about the purpose of user fees, even relatively low-level fees placed a significant financial burden upon impoverished households, and thus created a barrier to accessing care, which was not compatible with the philosophy of cost sharing purely for reasons of partnership. It was not until 1998 that there was any change in the official position. The question of the purpose of cost sharing was debated at some length during the Kafue Gorge meetings on the Comprehensive Health Financing Policy Framework, and the most recent wording of the financing policy document acknowledged a dual purpose for cost sharing.

It is difficult to say with certainty how this lack of clarity in policy affected implementation; however, because of the official stance that cost sharing was only for partnership reasons, there was perhaps less emphasis among reformers about establishing proper financial systems to manage fee revenue and ensure that it was appropriately spent. Although work was done on developing a facility-based Financial and Administrative Management System prior to 1996, this was never implemented and appeared to get "lost" during 1996. The precise reasons for this are unclear, but at the time, accounting for cost-sharing revenues and expenditures at the facility level was clearly not seen as a priority.

While the overarching vision was certainly important to the reforms, a number of former and current MOH and CBOH officials emphasized that the vision did not act as a constraint upon action. For example, the whole system of basket funding emerged more or less by accident; it was not part of the vision but came about due to frustrations with the existing forms of donor funding.

7.4.2 Consultation and Communication

The MOH in the Third Republic has prided itself on the consultative nature of its decision making. One former technical advisor described the typical consultative process in the following terms:

> *Generally, most issues in the health reforms were developed in a very democratic way, which became typical for the Zambian health reforms. In a first step an idea was born, either introduced by someone at the MOH or HRIT, or in some cases introduced by a donor. This idea was then discussed at the central level, i.e., within the MOH and HRIT. These ideas or concepts were thereafter introduced to representatives from the provider side, i.e., from districts, provinces, hospitals, and in many cases also involving representatives from other interest groups such as the CMAZ and sometimes the ZCCM. In the next step, the policy would be finalized at the central level, with aspects and opinions from the other levels taken into account.*

Other respondents have confirmed this pattern of consultation. For example, during the process of finalizing NHPS, views were solicited from a broad range of players, both from within and outside the ministry, and from the central to district levels [MOH, 1992a: Annexes 3 and 5]. Similarly, DHMTs were asked for their views as well as to consult with and get feedback from other district and subdistrict stakeholders during the HCFWG work on prepayment schemes. Work on the Health Financing Policy (1997-98) followed a similar pattern although there was no widespread consultation with districts.

This process of extensive consultation has had mixed results. (Table 7.2 provides more detail about the consultation processes.) Although it seems to have been very effective in developing widespread ownership of the NHPS, it may have been one of the factors delaying completion of the Health Financing Policy:

> *It was seen as being fairly straightforward; it wouldn't be that difficult to come up with a financing policy that everyone could agree on. But, after some time, say November-December when we came into the final draft discussions, when it was actually a document with proposals, the organizations that were affected maybe started looking a bit more thoroughly at the content of the policy, and then it became a bit more controversial.* (technical advisor)

The element of the policy that proved most controversial was the principle that health care users should only pay upon initially entering the health care system; this substantially threatened hospital

revenues and led to considerable resistance from hospitals as well as other levels of the health care system (interview data).

Table 7.2. Consultation Processes for Selected Individual Financing Reforms

Reform	Time Period	Process
Initial introduction of user fees	1993	Some discussion during District Capacity Building workshops, but no formal meetings specifically targeted at soliciting views on this issue.
Introduction of hospital-based prepayment	1994	HCFWG discussion paper sent to all districts, but proposed implementation process overruled by ministerial decree. Ministerial decree based upon consultation with small advisory group composed mainly of senior-level hospital staff.
Resource allocation formulae reforms	1994-5	Discussion with district, provincial, and hospital managers about possible criteria for inclusion in a formula for each level. Figures based on formula presented to Ministry of Finance and Economic Development (MOFED).
Health Financing Policy	1997-1998	Substantial consultation with different interest groups (e.g., insurance companies, donors, private providers, other ministries) through Kafue Gorge meetings. Less consultation with district and hospital level staff.
Cost-sharing guidelines	1997-1998	One large consultative meeting with health care providers from all different levels of system, community representatives, MOF, MCDSS etc., then guidelines circulated to all districts for comment prior to finalization.

Arguably, the greater barrier to effective implementation of reforms was not the process of consultation but that of communication. Several interviewees highlighted the lack of effective communication with health care workers and the general public about the reform program in general and financing policies in particular:

> *The users, the end users, they had very little knowledge about all this. All they were told is that you have to pay, you paid nothing yesterday, today you have to pay so much, so the consultation came very late.* (Zambian academic)

> *Another concern that the financing group had was the lack of information that was going out to people at district level. There was never any formal health financing policy. It was these ad hoc circulars that were sent out, and there was confusion at that level as to what the policy was since nobody had explained about user fees being introduced at district level and subdistrict level. No guidelines were given on how fees should be set, what type of fees should be set…* (former long-term technical advisor and HCFWG member)

> *More broadly, both in the financing and the institutional reforms, there's been a real failure to communicate to two key groups of stakeholders: the public and the health workers, which was kind of surprising, given the efforts to make sure that the private sector was on board, that*

traditional practitioners were represented. And even looking at the financing policy now, I was struck when I thought about it, that there was no one from the regional level, no one from the district level, and no one from the health center level who participated in any of the groups discussing the financing policy. (former technical advisor)

Failure to communicate effectively to the general public the objectives and modes of cost sharing is also a critical and continuing problem. Several studies over an extended period of time have noted this problem:

There was a widespread impression that the sudden and unexplained introduction of charges must reflect a Government decision to "punish the poor." (Booth 1995, p 42 – referring to Litoya compound, Western Province)

….users do not know how their money is being used and are highly suspicious of where it might be going. (Atkinson et al., 1996)

In each of the sixty communities where focus group discussions were held there was limited understanding of the purpose and nature of the overall program of health sector reform and a common understanding that the main thrust of health sector reform was the implementation of cost-sharing policies. (Daura et al., 1998)

To date these problems of communicating reforms to the general public have not been effectively addressed, though there is more discussion about the importance of effective communication, especially given recent concerns about the need for population-level impact.

The MOH and CBOH have used a number of different strategies to better inform health staff about changes, but there does not appear to have been any over-arching communication strategy. In 1994 and 1995 the annual general meeting, where districts met in Lusaka to get feedback on their draft plans and to receive any additional information for the coming year, was one forum through which reformers attempted to communicate changes.

More recently interdistrict meetings have taken on this role. On other occasions senior members of the CBOH or MOH traveled around the country attempting to explain and advocate reform strategies. For example, one CBOH official conducted such a tour of mission hospitals in Southern Province to explain the rationale behind new resource allocation mechanisms that linked allocation to ideal bed numbers (based on population) rather than actual bed numbers.

The failure to develop a comprehensive financing policy, and until recently the lack of guidelines on cost sharing, has undoubtedly adversely affected attempts to communicate central government policy to both health staff and the general population.

7.4.3 Relationship between Policy and Implementation

While the Zambian reformers have had a strong vision, one of the key problems encountered has been their inability to translate that vision into reality.

We have the global policy, but then we have meta-policies, these are operational policies. Sometimes I'm not so sure whether we should have so many of them and call them policies of the same grade, because now we have reproductive health, financing policy, drug policy, and all these… If you look carefully these should be operational policies because at the rate we are

churning them out... (MOH official)

We had managed to deliver the laboratory policy, reproductive health policy and so on, but these were simply software, they didn't, they were not visible as far as the public was concerned. (former Minister of Health)

A number of Zambian policy makers interviewed mentioned what they perceived to be an increasing tendency in the reform process to get bogged down in discussions of policy. As policy makers examined more deeply one particular issue, it fragmented before them and seemed to lead to a chain of associated policies. According to interview data, this certainly was argued to be the case for the financing policy, and it might explain the proliferation of small working groups on different aspects of financing policy described earlier. Furthermore interviews suggested that there was increasing frustration among Zambian policy makers with the lack of "on-the-ground" impact and that with this came a frustration with some of the protracted policy discussions going on. A number of possible explanatory factors underlie this perception.

First, at the beginning of the reform program, policy documents served to set out a vision and build consensus. At that point, policy makers tended to be more concerned about getting something off the ground rather than perfecting the policy. Reflecting on the NHPS, one donor representative argued:

It went through several iterations but it was never a beautiful document; it was a document that was a bit of cutting and pasting; it had some high-level policy content; it had some very detailed stuff about ministry, transport, requirements, and so on; it was always a bit of a hotch potch, and I don't think that really the quality of the document was the central thing. I think what was central in those discussions was this notion of building a consensus amongst a pretty broad group of actors in the health sector about the general direction they would like to go in.

It was also clear from interviewees that while the overall vision was important, early policy documents were viewed very much as working documents that could be amended as experience on the ground was gained:

And what we were also conscious of was the fact that this reform process, these health reforms, have to be dynamic, because the challenges, the problems that you're facing are dynamic, you can't approach them with a non-dynamic or a static program. So we actually expected continuous refinement of the reform process. After all, we're beginning with a set of ideas which we actually don't know whether they will stand the test of time in the field. (health official)

In contrast the Health Financing Policy document, which was worked on between 1997 and 1998, perhaps aimed to achieve too much. Some respondents argued that the Zambian track record on reform meant that many actors had unrealistic expectations of what this policy document could achieve. Thus during the decade of reforms under consideration, expectations about policies and the purpose of policies changed somewhat, and accordingly it became harder to deliver policy documents.

Second, although at the beginning of the period under review the small group of committed reformers within the MOH and HRIT could manage the policy development process, as implementation progressed so did the number of policy agendas that needed to be debated and agreed. Frequently there were simply not enough knowledgeable people to carry forward all the policy agendas at any one time.

Third, given the increasing complexity of policy documents and the limited capacity to work on such policies, a more selective approach was needed to choose which policies to work on. As previously hinted, policies that gained precedence were not necessarily those addressing areas commonly seen as having the highest priority. Which policies were actively developed was probably influenced by donor support and financing, as well as the presence of individuals with both the technical skills and the interest to take policy development forward. The lack of economic expertise inside government may also have reduced the likelihood of work occurring on financing policies.

Some external observers argued that the problem was not so much one of too much time spent in policy discussions but rather too little time discussing key aspects of the overarching reform framework, and this consequently led to lack of clarity on specific aspects of reform:

> *With the health care financing policy during the time I was in Zambia, I think many decisions that should have formed parts in a health care financing policy were rushed and introduced in a somewhat ad hoc way without the necessary evidence at hand, and a comprehensive policy was therefore never really developed. The process was led by ad hoc decisions and rushed implementation of various parts of a financing policy that did not exist and could not be developed as the direction was changed and new decisions and new policies were implemented all the time* .(technical advisor)

This quotation hints at a further problem in policy development. As time progressed a history of reform began to accumulate, which circumscribed future reform options, or at least created significant opposition to certain reforms. For example, the drafts of the financing policy suggest that hospitals should not charge fees to patients who have been referred from lower levels of the system, but as hospitals had already come to rely considerably on user fee revenues, this was found to be extremely unpalatable.

7.4.4 The Personal Nature of Policy Making

The interviews highlight how small the policy circle in Zambia was and the substantial informal links between those in the policy circle. Important links at the political level, between Kalumba and Chiluba, and between Kawimbe and the then minister of finance, have already been noted, but there were also critical personal links between academia and government and government and donors.

Kalumba was in many respects at the center of the network. He had strong links to the university, having previously worked in the Department of Community Medicine, and relatively strong links to bureaucrats in the MOH, having collaborated with them prior to MMD coming to power. In addition, he had a direct and personal connection to the president, and he managed to maintain strong personal links to several donor representatives. The one set of actors to whom Kalumba did not maintain close links was hospital staff. All other ministers appointed during the period under study had much stronger links in this area, and they exploited them when there was a disagreement between minister and deputy minister.[72]

[72] Kawimbe's link was through his background as a medical specialist; Sata's was through his wife, who was an obstetrician/gynecologist, and through other relationships that he nurtured; and Luo's was through her background as a UTH immunologist.

Some donor representatives, perhaps partly because of their personal relationships with the then deputy minister, were clearly willing to invest personal energies in the reform program and sidestep formalities. In Kalumba's words:

> *Let me say at 1991 now, 1992, early 1992, two people in particular, I'm trying to recall the third one, in the international network became very important...They became very instrumental in facilitating the networking, the selling of the new policy reform ideas, to the other players, connecting them to me, despite the fact that I was the deputy minister; they knew that's where the ideas seat was. So they were not being formalistic, they could do the courtesies but they would always advise, if you want to know what this government is trying to do in the area of health, talk to the deputy minister. I think that they played a very effective role there, which helped me to elaborate to people who were willing to look at our program more intensively.*

According to interview data, personal introductions were a common means to facilitate the entry of new consultants or technical advisors into the reform process, and personal connections between local policy makers and technical advisors helped ensure continuity in terms of advice and, more importantly, brought in people who could identify with the overarching vision of reform.

7.5 Implementation Processes

7.5.1 Capacity

Many respondents, but particularly external technical advisors, believed that the implementation of policy, as described in Section 4 and analyzed further here, suffered from lack of capacity. Different aspects of capacity were discussed as being constraints. At the simplest level there appeared to be too few people in the MOH and CBOH who fully understood the more technical dimensions of health financing reform; this constraint had become more evident as the reforms progressed and the number of areas in which solid technical input was required increased.

A scarcity of skilled health staff at the central level was one of the key factors contributing to the substantial influence of ministers (see 7.3.1). Another respondent observed the following with regard to the trial decentralization project conducted during the early 1990s:

> *People at the local level were unclear what they were meant to be doing, how they were meant to be handling funds, and there was insufficient capacity at the central level to clearly set that out. And I personally think that's a continuing problem with all aspects of the reform program, that there has been… a vision emanating largely from Katele Kalumba, but with support from other key players, but they have had great difficulty translating that vision into everyday operational guidelines*. (technical advisor)

Other advisors stressed the lack of capacity in bureaucratic systems, which adversely affected reform implementation. For example:

> *Pressure (i.e., through over expenditures) from more powerful hospitals and the CBOH has repeatedly resulted in less actual allocation to districts then planned. This very much reflects poor budgeting, accountability, systems, and procedures as much as real decisions to reverse trends. When the MOH does not receive its entire allocation, it is forced to prioritize and that prioritization process is not well developed, nor transparent.* (donor representative)

While respondents tended to focus on the problems that lack of capacity at the central level had posed to implementing health financing reforms, lack of capacity at all levels of the system proved problematic. Although reformers made a sustained and well-planned effort to improve district level budgeting and planning during 1993, much work was still required, and when capacity was not present, reforms could not always achieve their original intent. For example, one respondent suggested:

> *Reallocation of monies away from the central hospitals and towards districts has forced some hospitals to undertake some efforts to improve efficiency. However, it has pinched hospitals while not giving them the skills and accountability to operate with a lower public subsidy.* (donor representative)

Another example of where capacity constraints have destabilized reforms is the lack of adequate systems to manage user fee revenues, which contributed to the lack of impact of revenue on the quality of service.

More recently there has been considerable turnover among senior staff, which, as one respondent observed, has led to lack of institutional memory. One factor contributing to this turnover is the toll that HIV/AIDS has taken upon health officials.

Despite the fact that capacity constraints have formed a real obstacle to reform, there has been an increase in institutional capacity in health economics at the University of Zambia. One respondent suggested that focusing on building capacity in institutions outside of the ministry was the best way forward. However, the experience of the HCFWG indicates that external capacity may not be used effectively, even if available.

7.5.2 Sequencing and Pilots

Although reformers had a relatively clear vision of the goal of the reform process, at no point was there an explicit attempt to define an implementation strategy, or an appropriate sequencing of reform elements. For the two focal reforms, policy makers appear to have implemented changes as a need for change was brought to their attention, or as they found the means to address an existing concern. This rather ad hoc approach to sequencing implementation of reforms had differing effects on the two policies considered.

By and large the implementation of new resource allocation formulae and the associated reforms in planning and budgeting followed a rational sequence of events. At the outset, resource allocation reforms were clearly rooted in the original reform vision (notably the elements of decentralization and prioritization of peripheral services). Also, policy makers recognized the considerable problems of lack of capacity at the district level and developed a carefully planned and phased approach to increasing district capacity (as described in 4.5.1). In addition, there have been ongoing attempts to refine the resource allocation formulae further based on experience and new information, although these efforts have perhaps not been as successful or as extensive as necessary.

Although the implementation of resource allocation formulae followed a relatively rational sequence of events, it is clear that the sequencing of cost-sharing reform has been more problematic. In particular:

- Circulars announcing that cost sharing was allowed preceded any broader framework setting out the principles for cost-sharing.

- Cost-sharing strategies were expanded prior to capacity building measures to strengthen accounting for and managing cost-sharing revenues.

- Prepayment schemes at the hospital were announced prior to a proper assessment of their potential being conducted.

- Cost-sharing guidelines were formulated and disseminated prior to the finalization of the overarching health financing policy.

One of the underlying reasons for these problems appears to be that cost sharing was frequently not viewed as part of the broader package of organizational reforms, but as a separate and parallel reform. In addition to the many pressures responsible for inappropriate sequencing of policy implementation, the likely negative impact in terms of failure to use cost-sharing revenues effectively, the failure to exempt the truly poor, and the broad lack of the community's understanding of cost sharing all stem from problems of poor sequencing and need to be stressed.

In general the Zambian MOH has avoided piloting particular reforms, but where possible has chosen to implement a reform in an incremental manner. The reasons for this are unclear. One probable factor, which several interviewees hinted at, was a feeling that there was "too much talk and too little action." If reforms were to offer positive benefits, they needed to be implemented widely. Financial constraints may also have been a factor in that it might prove expensive to scale up a complex package of reforms from a pilot site. Further, political considerations were probably at stake: pilots in certain areas might give the impression of political favoritism or tribalism. Consequently, pilot implementation of financing reforms was conducted for only two aspects of reform,[73] namely decentralized district budgeting (1991-1993, described in Section 4.2.2) and the Health Care Costs Scheme (see Section 4.6.3). Experience with these two pilots differs considerably. Although both were at least partially successful during the pilot phase, district budgeting was rapidly expanded to all districts whereas the HCCS has not moved beyond a pilot basis to date. The explanation for these differences needs to be addressed.

The trial project on district budgeting developed out of joint ministry and donor concerns about the effectiveness of the existing health service, particularly the system of funding districts through the PACU, together with international policy moves towards decentralization. It provided a good example of different government ministries (MOFED, MOH) and donor agencies (SIDA, UNICEF) working together. In this case, although the decision to move to scale had in effect been taken prior to the external evaluation (Bennett, 1993), an internal review of the process had occurred in February 1993, and some of the early discussions between the Danish International Development Agency, MOH, and other donors regarding the process of introducing direct district funding were built on this.

Officials within the MOH sensed that it would not be possible at the time to get approval from the MOF to pull all districts out of the PACU system of funding. Piloting this arrangement helped to get donor support behind the idea and also demonstrated to the MOF that such an arrangement would work. This in turn strengthened the hand of the MOH when it argued in favor of shifting all districts to a system of decentralized funding.

The HCCS was developed jointly with the Ministry of Community Development and Social Services (MCDSS) in 1995 (see Section 4.6.3) and an evaluation was undertaken in 1997, which

[73] At times the hospital prepayment schemes were referred to as '"pilots," but it is unclear in what sense they were pilots.

recommended rolling it out to all districts. However, to date this has not occurred and there remains confusion in the sector regarding exemptions based on ability to pay.

A number of factors appear to have contributed to this impasse. First, a review of the HCCS should have been part of a complete review of the Public Welfare Assistance Scheme and was to some extent delayed, as it needed to be coordinated with broader revision of the PWAS. Second, MOH has had limited ownership of the process with the bulk of work being conducted by MCDSS. Third, changeover in key staff in MCDSS has adversely affected the pace of change. Finally, in the words of one informant:

The bottom line is that the money is not sufficient to cater for the problems which are being experienced. (MOH official)

7.5.3 Monitoring and Evaluation

Initially reforms in resource allocation formulae were implemented without any system of monitoring or evaluation in place, although there had been an evaluation of the trial decentralization project (1991-1993). From 1995 on, however, there were substantial efforts to develop systems within the MOH and CBOH to review disbursements to districts. Although these monitoring systems were in place, however, they have not been properly operated. The key issue here appears to be the highly political and sensitive nature of data on funds actually released and spent, which means that it is not always desirable for these systems to be fully transparent. For example, while resource allocation formulae increased transparency in budgetary allocations and may have prevented more political budget allocations, actual allocations did not always follow budgeted ones. Systems were developed to monitor actual allocations, but these systems were never routinely operated mainly because of "*political unwillingness"* (interview data – former technical advisor). Moreover, for much of the period of study, no Budget Steering Committee was in place. This committee formally has responsibility for monitoring budgetary allocations on a monthly basis, and the lack of such a committee was in part a consequence of the political sensitivity of actual budgetary allocations. This obviously also weakened the monitoring process.

Although a monitoring and evaluation plan was never integrated into the cost-sharing reforms (mainly because there was no overarching implementation plan), a number of evaluations of cost sharing have been conducted (Booth et al., 1995; Kahenya and Lake 1994; Kalyalya and Milimo 1996; Kalyalya et al., 1998; Daura et al., 1998). The impact of these evaluations has depended largely on timing and whether the recommendations made found a hostile or welcoming environment. For example, recommendations by Booth et al., 1995, suggested that fees should be linked to drugs rather than less tangible aspects of service. However, Minister Sata had relatively recently and very publicly abolished fees for drugs and thus was unlikely to consider their reintroduction. Similarly, while issues of communicating the purpose and form of cost-sharing reforms to the general public was frequently identified in the recommendations of evaluations, its implementation was hampered by the lack of an overall financing policy, and therefore uncertainty as to exactly what should be communicated.

One major evaluation conducted during 1996 was supported by the World Bank and UNICEF (MOH/WHO/UNICEF/WH, 1996) and covered health finance as one element. The evaluation's findings were very slow to emerge, however, and although the evaluation certainly raised the profile of reforms internationally, one respondent argued that:

It didn't seem to me that it served its internal purpose in terms of identifying what was key, what

they should really get moving on. (former technical advisor)

The financing component of the overall evaluation was also weakened by the fact that the external consultant responsible for financing was unable to work with any local counterpart and therefore may not have been as attuned to local priorities as he should have been. This again reflects the effect of limited local capacity on ability to manage external consultants and advisors (see 7.3.3).

7.6 Summary

The broader political and socioeconomic context was certainly a critical factor in influencing policy processes in health financing reform in Zambia. As in South Africa, the change in government not only provided a political window of opportunity for reform but also created pressures on the reform process. Furthermore, the political context, combined with lack of technical capacity in the MOH, gave individual ministers considerable influence over the reform process, which in the case of health financing reform contributed to the stop/start nature of reforms and relatively frequent changes in policy direction.

Zambia is the only low-income country that has embarked on such a radical and fast moving program of health sector reform. During the period of study, the health sector faced the dual problems of dwindling government budgetary resources and increasing demands on services due to the increasing burden of HIV/AIDS. Whether or not reforms were implemented, the health sector would have faced a very difficult decade. Furthermore, the particular characteristics of a low-income country such as Zambia served to undermine some of the specific financing reforms considered. Most important perhaps is the limited capacity, in terms of human resources, organizational systems and structures, and funding, to undertake technical health financing work.

This section has described a number of ways in which limited capacity adversely affected financing policy development and implementation. There are some obvious direct effects of lack of capacity: lack of technical capacity meant that reforms were not always implemented in a rational manner as necessary guidelines or that overarching policy frameworks were not in place. Reforms were frequently implemented without clear objectives, without adequate guidance given to the implementers, or without a sufficiently strong monitoring and evaluation framework. Lack of capacity in the MOH and CBOH also affected the role that other actors played:

- *Ministers of Health* – weak technical capacity within the MOH and CBOH contributed to the influential role played by ministers of health.

- *Technical advisors* – commonly worked without local counterparts. This in turn meant that there was not always strong MOH ownership of their work; there was sometimes a temporary suspension of work after the departure of technical advisors, and consultants were not always sufficiently attuned to the local context.

- *Donors* – dependence on donor funding for technical analysis, dissemination, and training meant that donors, consciously or unconsciously, commonly helped set priorities, and it was not always possible for the MOH and CBOH to proceed with their own priorities.

Despite the problems associated with limited technical capacity, there were also instances when technical advice was ignored or overruled. In particular, advice given by the HCFWG was not taken into account when planning prepayment schemes. The political environment was the primary reason for this, but the HCFWG was also hampered by the lack of a clearly defined position. A clearer

definition of its roles and responsibilities and relative position within the health sector may have made the group appear more "objective" and made it harder for ministers to ignore advice from this body. Furthermore, clearer role definition may also have helped with the coordination of the large number of smaller working groups now active in different areas of financing policy.

Issues of capacity and context affect both resource allocation and cost-sharing reforms and hence do not provide straightforward reasons why one was more successful than the other. From this analysis, a number of other factors were important. First, while resource allocation policies were clearly viewed by all concerned to be an integral part of the initial vision and a key component of the decentralization reforms, cost sharing was always viewed to be something rather different. This meant that the objectives of cost sharing were never as clear as the objectives of resource allocation. This need not necessarily have been the case; during the late 1980s and early 1990s one of the primary models of health financing reform, discussed not only in Zambia but more broadly in Sub-Saharan Africa, was the Bamako Initiative, which closely linked financing reforms with district management strengthening and community involvement.

Second, resource allocation reforms (with the exception of one component of the policy) never became as politicized as cost-sharing reforms. This is interesting in that in other contexts resource allocation reform has been highly politicized.[74] The reasons for this are unclear, but it is possible that the unstable economic environment (which in any case leads to frequent changes in budget allocation) and the fact that districts were not accustomed to receiving their own resources were contributory factors. The one element that did become very sensitive was allocation of funds between hospitals and districts: sensitivity over this issue also reflects the perceived differences in allegiances of different ministers of health. In contrast, cost-sharing reforms were very politically sensitive and, as a consequence, policy development proceeded through a series of ministerial decrees. Unfortunately these decrees not only prevented the development of a holistic cost-sharing policy framework but also served to politicize the issues further.

A second question posed at the beginning of this section was why it had proved so difficult to finalize the Comprehensive Health Financing Policy. During the early years of the reform program the government appears to have shied away from this area partly because of lack of technical capacity to develop the policy, but also perhaps because there was no clear sense of what such a policy should cover. However, efforts during 1997-1998 to develop the policy also were left incomplete. Clearly the change of ministers that occurred while the policy was being finalized, and the different priorities that they held, affected finalization.

In addition, the analysis suggests two further important points. First, an underlying theme of the Zambia reforms has been the redistribution of power and resources from hospitals to the district level. As noted earlier, one of the most controversial points on the financing policy document was that once someone had visited a first-level facility and paid fees at this facility, they were entitled to free care at higher level facilities. This element of the policy was likely to upset the relatively powerful interests within hospitals – compromise on this one issue may have made the policy as a whole considerably more palatable. Secondly, it seems that the policy became much more complex and comprehensive than perhaps had been initially envisaged. This also is a more general feature of reforms in Zambia; initial broad reforms proved much easier to formulate than the more detailed (and technical) policy documents necessary to achieve implementation of the broader vision.

[74] See Mays and Bevan (1987) for an account of the development of resource allocation formulae in the United Kingdom. (See footnote 58).

Table 7.3. Overview of Policy Successes and Failures, 1991-1998

Successes: Policy Development	Explanatory Factors
Introduction of user fees following change of government	Recognition within the sector of inadequate resource base Inclusion within MMD manifesto therefore in principle population was informed of policy intent Rational process of bringing in external consultants to assess feasibility of different modes of cost sharing Go ahead from MOF despite being contrary to existing government regulations
Commitment to use of a formula in order to move towards equity in the geographical allocation of resources	High level of political will/strong leadership within the MOH Support from MOF/government
Flexibility in consideration of different cost-sharing options	Awareness among high-level policy makers of a number of different financing mechanisms Donors willing to work with government to adapt cost-sharing approach to particular needs of country rather than push particular approach
Weaknesses: Policy Development	Explanatory Factors
Failure to finalize overall health financing policy	Low position on policy agenda Influence of the minister (1994-96) Over-consulting (1997+) Technical/analytical capacity Fragmentation of different groups involved in HF policy development (1998+) - linked to noneffectiveness of HCFWG
Poor design of the 1994 prepayment scheme, which reversed some positive impacts of earlier policy change	Top-down decision making Influence of the minister Lack of effective voice of HCFWG Priority given to political rather than technical processes
Successes: Policy Implementation	Explanatory Factors
Flexibility given to districts to implement according to local conditions and to consult with users	Support for policy of decentralization (in early years) and recognition that different districts faced different circumstances and should proceed differently Political commitment to creating greater downward accountability
Use of pilot project in development of decentralized budgeting and accounting	External support in terms of TA and funding from SIDA Effective consultation with MOF to gain support
Weaknesses: Policy Implementation	Explanatory Factors
Failure to clarify cost-sharing policy position with implementors and users	See failure to finalize HF policy above Limited capacity Low position on policy agenda (cf decentralization) Confusion/disagreement among high-level policy makers and donors about purpose of cost sharing
Failure to implement user fees in accordance with stated policy in	Political decision making

NHPS (flat fee, non-RHC)	Focus on decentralization rather than financing, and thus decision to allow more autonomy to districts in setting of fees
Failure to move the HCCS forward and go to scale	Limited effective support at MOH central level/low position on policy agenda Limited resource availability to finance scheme Capacity constraints (PU/HRIT/CBOH- limited number of people and many agendas)
Hasty and ill-thought-out 1994 prepayment scheme	Effective lack of autonomy at board level Influence of the minister Lack of consultation Lack of effective HCFWG
Continued lack of transparency in resource allocation at central level	Overall resource constraints due to poor macroeconomic environment Lack of political will Nonexistence (effective) of Budget Steering Committee to oversee allocations on monthly basis

8. Lessons and Conclusions

8.1 Overview of Experience

Since the change of government in 1991, Zambia has initiated an ambitious program of health sector reform and restructuring to reverse the decline in service delivery seen over the previous decades, and thus to better address the new and re-emerging health problems the population faces. This has taken place within the context of broader governmental reform, but it is generally acknowledged that progress began earlier and has proceeded faster in the health sector. Overall, the approach taken by the Ministry of Health has been one of incremental progress toward a clearly stated vision and of "learning by doing." In the words of the then Permanent Secretary, *"the ability to adopt an organic step-by-step approach to dealing with issues, while retaining overall consistency and vision has fostered domestic ownership and leadership of the reform process"* (MOH/Central Board of Health 1998: iii). The vision itself had been agreed on prior to the Movement for Multiparty Democracy election victory, and articulation of the reform policies was thus able to proceed rapidly following the appointment of sympathetic and committed leadership in the MOH.

In general, the progress of the overall reform program has been viewed favorably. A 1996 external review team prefaced their main report with the statement that: *"(w)hat we have read and seen of the health reform in Zambia is something remarkable in Africa – a movement based on the principles of equity, accountability and partnership. It is a spirit which permeates through all its implementation activities"* (MOH/WHO/UNICEF/ World Bank 1996). However, as is often the case, different elements of the reform have either moved faster or been more successful than others, and in the case of health financing, there is much to be learned from this review of policy design and processes.

Both decentralization and health financing policy reforms have the potential of being highly politically sensitive. Despite the generally *ad hoc* nature of health financing policy making, this study highlights some notable achievements. Given the turbulence within the health sector due to frequent changes of political leadership in a context of economic decline, the fact that the broad policy of cost sharing has not been reversed is in itself a significant achievement.

Gaps clearly remain, however, and there is scope to strengthen both the design and implementation of health financing policy in Zambia. Some of the major successes and failures are summarized in Table 8.1. Arguably, the major gap is that after several years of active policy discussion and implementation of selected cost sharing and resource allocation mechanisms, there is still no overall framework to guide health financing reform. This is partly a result of political turbulence arising from frequent changes of leadership within the ministry, with a subsequent "stop-go" sequence of events in the policy development process.

Table 8.1. Financing Policy Achievements and Gaps

Policy Achievements	Explanatory Factors
Successful policy actions	
Introduction of cash prepayment in three districts reversed decline in utilization	Clear policy statement regarding equity of access
1995 clarification of exemption policy with regard to under fives and the elderly appears to have been largely successful, with these groups less likely to have paid for health care in public facilities	Demographic exemptions relatively easy to implement Clear policy
Implementation of formula for district grant allocations, resulting in move towards geographical equity at least between provinces	Clear policy objective stated in NHPS Pace of decentralization reforms placed resource allocation policy high on agenda Demonstration of potential gains from district funding by pilot in three districts
Weaknesses of policy actions	
Introduction of cash prepayment scheme at third-level referral hospitals resulted in inefficient use of the referral system by members, thus compromising sustainability	Policy imposed by then minister without any technical input Weak autonomy of hospital executive directors to make their own decisions regarding local revenue generation Nature of relationship between minister and executive directors of hospitals meant that they were unlikely to protest
Cash prepayment scheme reduced revenues, which combined with increased utilization (due to moral hazard)	As above
Lengthy delay in issuing guidelines to districts regarding design of cost-sharing schemes and use of revenues	Political turbulence which put all cost-sharing policy development on hold in 1994-1995 Subsequent move away from incremental process toward definition of the perfect policy document
Gaps in policy action	
Lack of system to routinely monitor impact of cost-sharing reforms on utilization of health services, both generally and by particular groups	
Lack of specific equity target against which to monitor inter-district resource allocations	Formula developed in response to urgent need for transparent mechanism following decision to directly fund districts

In addition, there is a clear need to revisit the issue of the policy for exemptions. This is linked both to the finalization of the financing policy framework and to concerns raised earlier in the report regarding the need for clarification of the overall policy objective of cost sharing. An exemption policy becomes more critical if the primary objective is to raise revenue and fees are levied at an economic level, as potential financial barriers to access are likely to be greater. If, on the other hand, the idea behind charging is to solicit nominal payments to promote a sense of partnership and a climate in which beneficiaries are inspired to demand quality and access, the issues are somewhat different.

The sections below present conclusions and recommendations drawn from the preceding sections. These are separated into three categories: first, lessons regarding the process through which financing policy in Zambia has been developed and implemented over the period 1991-1999 are highlighted; secondly, some specific recommendations are made regarding the technical design of those reforms considered in the study; and thirdly, some proposals for strengthening the implementation of financing reform are offered. These recommendations are primarily targeted at national level policy makers and managers within Zambia; however, they do have implications for managers at the implementation level, i.e., districts and hospitals, and for provincial managers at the intermediate supervisory level. In addition, through their overall contribution to the body of international literature on the subject of financing reform, these recommendations are also directed at an international audience.

8.2 Strengthening the Process of Policy Formulation

The discussion of the policy process is considered first as it has repercussions for subsequent recommendations regarding design and implementation of financing policy reforms. While strong leadership in the Ministry is a prerequisite to effective policy making, particularly in moving from "talk" to "action," it is important to ensure that the process is driven by technical considerations. The realities of vested interests and personal political preferences, however, cannot be ignored. In Zambia, it has been shown that cost-sharing policy development has alternated between a rational, informed, consultative process (at least at the central level) and *ad hoc*, top-down statements by ministers introducing new and untested schemes. To the extent that this is due to the particular nature of individual politicians, it is inevitable that the process should be less than perfectly smooth. The political dimension is not something that will go away, and the key issue is therefore how to build stronger institutions to ensure that political-driven change is not overwhelming. There are a number of actions that can be taken to ensure that some of the worst effects of such "changes" are avoided. Many of the issues raised here are interlinked and could be equally highlighted in later sections.

8.2.1 Improving Technical Health Economics Capacity

Growing recognition of the important role of health economics in strengthening health systems generally, and health financing reform in particular, is an international phenomenon. Zambia acknowledged a need to strengthen capacity in this area relatively early, with recruitment of external advisors in the field stemming from before the change of government occurred in 1991. Subsequently, Planning Unit staff have undertaken in-service training, and graduate economists have been recruited to positions in the Ministry and later in the Central Board of Health. However, the number of full-time trained health economists within government positions remains small.

In addition, the few health economists who are in the system have not always been used to their full potential. The daily bureaucratic workload of civil servants during a period of radical restructuring has meant that the time they have available for technical issues has been rather limited. As part of a small but highly regarded Planning Unit in the early years of the reform process, the economists spent much of their time as liaisons with donor planning or review missions, or in the minutiae of budget preparation processes. Meanwhile, cost-sharing policy was ignored following the issuing of the February 1993 circular, and no counterpart was assigned to follow up the work of the 1992 technical mission on health insurance. More recently, the political decision to transfer the two health economists to completely unrelated positions managing support from one particular donor represents a waste of core skills, in addition to having a demoralizing effect on the staff concerned.

This perhaps illustrates the lack of understanding among senior policy makers of the potential role of such technical staff.

Over the past few years, perhaps in recognition of the constraints upon internal MOH health economists, the Swedish International Development Agency has sought to strengthen health economics capacity at the university as a resource that is then available to the MOH and CBOH for technical input into the policy process. This move from long-term foreign technical assistance directly within the MOH structure, to collaboration with an overseas institution, appears to be working well and is likely to be more sustainable. In addition, the establishment of regular meetings between the MOH and CBOH as "commissioners" of policy-relevant research and the university as "contractees" means that there is a greater chance of research findings being absorbed into the policy design and implementation process.

8.2.2 Revitalizing the Role of the Health Care Financing Working Group

The decision to create a multidisciplinary technical body, comprising members drawn from both within and outside the government sector, to coordinate and advise on health financing matters (see Section 4) indicates the seriousness with which Zambia initially approached the subject of health sector reform. As discussed in Section 7, however, the Health Care Financing Working Group has largely failed to make a substantial impact in steering the policy process forward. Although a large and changing body of members has probably contributed to this failure, the relative lack of political backing has been the major problem. This has manifested itself both directly and indirectly over the period under study. For example, during the years Sata was minister (1994 and 1995), it was believed the group reflected Kalumba's views and therefore was seen as opposing the minister in his plans to introduce prepayment. More recently, during Luo's tenure as minister, the planning directorate appeared to be out of political favor, and the resulting reduced capacity frustrated the HCFWG secretariat, which was based in that directorate.

For such a body to play a useful role in countering interference from a changing political leadership, it must be accepted as a formal MOH/CBOH structure and not seen as an instrument of any particular minister or policy maker. Despite the shortcomings outlined above, Zambia has the capacity to do much in country if it uses existing technical skills to their maximum effectiveness. It is therefore critical to ensure that technicians such as a well-constituted HCFWG have a clearly defined role in policy-making processes so that they cannot be easily overruled or ignored.

A number of other steering committees and working groups currently exist in the health sector, several of which relate to specific issues of financing (see Section 7). It is recommended that the HCFWG or a similar body be reconvened to coordinate activities in this area, to ensure overall consistency with the emerging health financing policy framework, and to identify any gaps. Any technical work would then be commissioned by this group, to be undertaken by smaller working groups which would then report back through systematic and established communication channels, rather than *ad hoc* as appears to be the case at present. This steering group should be relatively small, but should involve key non-governmental representatives in order to provide an interface between different providers and users or civil society. In this way, as with the increased use of commissioned research through the university outlined in the previous subsection, the uptake of research findings is likely to be enhanced.

8.2.3 Availability of an Overall Health Financing Policy Framework

Another means of strengthening the policy process and avoiding "turbulence" would be to finalize the financing policy framework that has now been almost three years in its development. Although the Zambian philosophy of "learning by doing" has had advantages in some areas, in the area of financing, critical policy actions have been delayed by the absence of a document or at least some general consensus on the core objectives of financing reform and the interrelationships between financing and organizational reforms. There have been critical and relatively simple actions that could have been taken during the process, and these could have strengthened implementation (e.g., guidelines regarding charging for drugs or use of revenues). The failure to take such actions has often been referred back to this lack of a "policy." The recently issued guidelines refer to the main financing policy for more detail, yet this is still not available as an official document for policy implementors (see below for more detailed discussion of sequencing).

8.2.4 Timing and Phasing of Reforms

The phasing and sequencing of reforms require much more attention than they have been given. Although there is some evidence from policy documents and interview data that fees were seen as a necessary prelude to the introduction of risk-sharing measures, in general, timing issues were not considered in the Zambian context. The long-term vision for both reforms as a whole, and more recently for health financing reforms, has been clear (see Section 5.1), but there has been no long-term strategy for achieving them. As stated in the 1996 evaluation of the reforms, *"[o]nce the wheels of change begin to turn, there is the urge to go as fast as possible to take advantage of the favourable conditions for as long as they persist. In Africa, these moments come and go very quickly"* (MOH/WHO/UNICEF/ World Bank 1996). In Zambia, particular windows of opportunity have sometimes been exploited, such as the reintroduction of cost sharing early in the life of the new government when political support was high. However, the wisdom of declaring a policy change without any clear plan for implementation or monitoring is questionable.

Routine planning processes within the health sector have been substantially strengthened since the start of the reforms. This has occurred at the district level through district capacity building and subsequent processes and through development of systems (see Section 4), while at the central level, the introduction of the biannual meetings between MOH, CBOH, and partners has encouraged cooperation and coordination. These processes provide useful fora for ensuring that work on health financing, ideally overseen throughout the year by a body such as the HCFWG, is reflected in strategic plans at the central level and operations planning at the district and facility level. Recent versions of the strategic plan have summarized the position regarding the overall financing of the health sector, and to some extent thinking on the role of cost sharing, but without clearly outlining proposed development in terms of implementation and monitoring. The additional advantage of incorporating priorities into such formal agreements is that it ensures that partners are involved from the discussion stage, thus minimizing potential conflict caused by individual partners unconsciously setting priorities.

The limited capacity referred to above means that Zambia cannot do everything at once, and therefore there is a need to prioritize competing reforms. This was illustrated most clearly with the HCFWG's one-year hiatus while district capacity strengthening took precedence. Financing must be seen as a critical component of sectoral reform, with implications for all other policy development and implementation. Consequently, the core role of the planning directorate in strengthening financing policy and implementation within the restructured MOH requires establishing an appropriate staff and clearly defining roles within the directorate. This should be addressed at the

earliest opportunity to take advantage of the ongoing central level restructuring and to facilitate appropriate support for CBOH and the implementation levels.

8.2.5 Consultation and Communication

One constant criticism this study found in evaluating various aspects of health financing reform has been the failure of the central level to consult and inform the periphery. This applies both to limited consultation with health staff at district and facility levels and to the relative dearth of information provided to the general population regarding policy developments and their rights and responsibilities. Again, this is linked to the issue of the slow development of an overall financing framework and to the attitudes of particular ministers. At several points over the period of study, those involved have stated their intentions to increase awareness regarding fee levels and exemptions, but in the absence of an approved overall policy, such activities have been delayed.

At the same time, as was outlined in Section 7, there may have been excessive central level consultation around the overall policy development, with a succession of large meetings and small working groups, and review and re-review of the outputs. Such consultation, however, has failed to adequately involve key players, namely implementers and beneficiaries.

8.2.6 Keeping Health Reforms in Line with Reforms in Other Sectors

The study, and particularly Section 7, shows the extent to which the health sector has benefited from strong political commitment and internal leadership, which has enabled it to proceed with radical reforms in advance of the rest of government. There are certain advantages to being such a front runner, but there may also be considerable disadvantages, particularly if dialogue is not maintained. In Zambia, the need for harmonization of broader government policies for civil service reform and for decentralization will be crucial in the coming years.

As a particular example of the nature of this problem, plans to restructure the overall government budgetary process away from the traditional incremental approach to an activity or program-based budgeting system have been ongoing since 1996. The motivation behind this is that planning and budgeting processes in all line ministries and government agencies should reflect resource availability (scarcity) and become more output-oriented with the activity-based budgeting system in place. This would also make ministerial allocations more transparent. Unfortunately this system, despite being announced in the 1996 government budget speech and accepted by parliament, has never been fully implemented and, as such, central government budgetary allocations to MOH have continued to be made on an ad hoc basis. Even senior MOH officials interviewed disclosed that they do not know the criteria that the Ministry of Finance uses to make ministerial allocation, stating that *"as government we should acknowledge that we are not doing well as far as priorities are concerned."* This shows that although improvements in financial resource allocation have been made within the MOH, these are a step ahead of the progress in government finance as a whole, and this limits their achievement.

8.3 Strengthening Technical Design

8.3.1 Clarifying Objectives

A constant theme of this report has been the failure of the MOH to clarify the objectives of financing reform and the oscillation, in terms of cost-sharing reforms, between partnership and revenue raising as its primary motivation. Future policy development must ensure that the objectives are clearly defined, otherwise the MOH and CBOH are likely to encounter considerable difficulties in translating broad reform ideas into detailed policy design. Lack of clarity with respect to objectives will also hamper communication of policies to implementors and users of the health system (as described below).

8.3.2 Specific Design Features

Many of the design problems with existing cost-sharing schemes, as identified in Section 6, have already been addressed with the subsequent issuing of guidelines (CBOH 1999a). For example, decisions regarding the need for a waiting period between joining and using a prepayment scheme, and clarification regarding the retention and use of cost-sharing revenues, are clearly spelled out in those documents. However, some issues remain to be addressed.

In a system that has equity of access as a policy goal, the introduction of fees necessitates a clear and effective exemption policy. The study has shown that while exemptions on grounds of age or for specific priority services are working relatively well, their implementation and monitoring have been weak in some parts of the country. This is something that should be followed up by routine performance audit by the reestablished provincial structures, and through continued use of participatory beneficiary assessment of reform impact.

When it comes to exemptions on the grounds of ability to pay, the overall picture is one of relative failure, although it is important to stress that the responsibility for developing such exemptions does not lie primarily with MOH. The Health Care Costs Scheme, while only achieving pilot status, appears to have potential, but it needs to be more fully integrated into the existing Public Welfare Assistance Scheme, which in turn requires capacity strengthening and an increase in the financial resources within the host Ministry of Community Development and Social Services. Although this is beyond the remit and ability of the MOH, MOH can still lobby for this as the success of the scheme directly impacts on the perceived success of the financing reforms, which are a key component of the overall reform process.

Success of the Health Care Costs Scheme also requires more demonstrated commitment by the MOH and CBOH in mainstreaming it within both the financing policy and Financial and Administrative Management System. Again, district health management team and health facility responsibilities in respect of such an exemption scheme must be clearly spelled out to ensure that implementation occurs as intended, and verification of this should be incorporated into the performance audit. If, as appears to be the case, progress with development through MCDSS is delayed, MOH should consider taking the lead in this area as the presence of continued financial barriers to access detract from the potential positive effects of the reforms.

Some of the worst design features of the prepayment scheme have been addressed through the closing of the scheme at the hospital outpatient department level, the remittance of some revenues with referrals, and the introduction of a “waiting period.” However, the scheme remains flawed. In

particular, the failure to set any limits on the use of the card once paid for, and the assumption of a complete benefit package for such a low premium, fostered moral hazard. This was aggravated by a situation whereby the shortage of drugs in the public sector facilities meant that it was rational for users to adopt the practice of visiting several facilities to "collect" drugs for future use.

A prepurchase scheme may offer a solution to many of these problems, but during the period under study, the pilot prepurchase scheme was suspended due to a combination of implementation problems and a transfer of responsibility for technical support by the donor partner. Although the MOH and CBOH have not abandoned the idea of prepurchase (it appeared in the 1999 Guidelines as an option for districts and facilities to pursue) (CBOH 1999a), this type of interruption does little to foster confidence at the implementing level and can create confusion.

8.3.3 Linkages between Financing Policy Change and the Broader Reform Package

One of the major failings of the process of health financing policy development to date has been the tendency to view it as an isolated set of reforms, rather than part of a holistic sectoral transformation. For example, a valuable opportunity for strengthening implementation and monitoring capacities was lost in 1993 through the failure to link the reintroduction of cost sharing into the district strengthening exercises prompted by decentralization. This may be attributed to a number of factors. The overall shortage of skilled or experienced personnel in the area of health financing and economics (mentioned in Section 8.2.1), together with the multiplicity of competing demands on those staff at a time of rapid activity, is one such factor. The separation of responsibilities for financing and decentralization, both between the MOH and Health Reform Implementation Team and between individuals prior to the establishment of the HRIT, is also likely to have contributed to this failure to identify opportunities for attacking on multiple fronts.

Similarly, current drafts of the financing policy refer to the concepts of cost sharing and cost recovery in relation to the Zambian package of services. However, the failure to finalize definition of this package at the hospital level and the limited extent to which the package is actually implemented in terms of staffing, drugs, and other components at the district level mean that as yet these statements have little meaning.

8.4 Strengthening Financing Policy Implementation

As discussed in Section 8.2, successful health financing policy involves not only the issue of technical design, but also careful consideration of mechanisms to ensure that implementation proceeds along desired lines and that the intended objectives of the policy are achieved. Two particular issues stand out as requiring further work in Zambia.

8.4.1 Involving Implementors and Users

The issue of consultation has already been raised as an essential component of the policy process. This is perhaps most critical in relation to the translation of a given policy statement to actual implementation. Consulting with those who work directly with the public and whose role is expected to change with the introduction of the policy reform is important as they will be most able to identify potential hurdles. One of the main reasons behind the decision to devolve responsibilities and resources to districts and hospitals was to capitalize on their knowledge of local needs and their

relatively greater understanding of the local context in order to improve the responsiveness of service delivery. This is equally applicable to financing policy change.

It is also necessary to better communicate the rationale and mode of operation of cost-sharing reforms to the general public. The 1999 guidelines stipulate that fee levels and exemptions should be clearly posted in health facilities, but means must also be found to inform those who are not currently using health services and to ensure that their concerns are addressed. There is a clear role for the health center committees and neighborhood health committees in this area.

8.4.2 Mainstreaming Monitoring and Evaluation Activities

The delay in the development of appropriate monitoring systems for both cost-sharing and resource allocation reforms is one of the most obvious gaps in the process of Zambia's health financing policy. While a philosophy of "learning by doing" is useful in a time of transition and major political change, the "learning" is only possible if mechanisms exist to monitor change and to feed back lessons into the continuous process of policy refinement. At the same time it is important to recognize that this gap may reflect a deliberate stance by the MOH, given the political nature of discussions around expenditures at the central level. The continued lack of enthusiasm regarding the establishment and functioning of the Budget Steering Committee has been one example of this. At the provider level, it may be that the failure to routinely monitor actual allocations has made the implementation of resource allocation reforms more palatable.

There is, therefore, an urgent need to improve data and develop an inclusive system for monitoring all sources of financing within the health sector. This is particularly the case for budget and expenditure information within the MOH, which must be monitored on a clear and timely basis to ascertain whether resource allocation policy is meeting objectives. The development of the National Health Accounts should go some way in addressing this, as will further specification of the broad set of indicators to be included in the strategic plan.

Based on these conclusions, a comprehensive capacity assessment should be undertaken to identify the existing position and any additional requirements in terms of human resources and financial systems. Knowing the capacity of existing resources and systems should lead to better reform strategy. For example, if there had been better understanding of the weaknesses in financial management at periphery, then MOH may have been more circumspect in introducing cost sharing when it did.

In addition to strengthening information systems and feedback loops within the health system, the need to capture user and, more importantly, nonuser views is critical. As already mentioned, the changed role of the public in relation to accessing health services must be communicated before implementing the system. Continued monitoring is essential to ensuring progress towards equity goals.

8.5 Moving Forward

Although this report has been concerned specifically with health financing reform, it has repeatedly emphasized the broader context within which changes occur. In particular, several interviewees stressed the connection between health sector reform and broader social reform. In the eyes of its architects, health sector reform in Zambia, including health financing reform, was part of a

larger effort, reflected in MMD policy, of redefining the nature of the relationship between the citizens and the state in Zambia.

Understanding health financing reform from this broader perspective has a number of implications. First, by their very nature the reforms reviewed here are long-term efforts. For example, effective implementation of the cost-sharing policy requires the general population to change its attitude toward the role of government. There are some signs that users are increasingly accepting of the need to pay user fees, although problems of affordability remain. Secondly, success of the reforms needs to be assessed at least partially with respect to the broader objectives of social transformation. While these processes clearly have many problems that need to be addressed, the reforms have at least been successful in initiating a train of change. Finally, while reforms within the health sector, particularly health financing reforms, appear to be entering a period of consolidation, reforms in other sectors are just getting underway. In the medium term, reforms in other sectors in Zambia should help consolidate the reforms reviewed in this study.

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